Prominence Health Plan

Prominence Preferred Health Insurance Company Certificate of Coverage

YOUR LARGE GROUP CERTIFICATE OF COVERAGE

This is Your Group Certificate of Coverage (COC) with Prominence Preferred Health Insurance Company, Inc. (herein referred to as "PPHIC"), 1510 Meadow Wood Lane, Reno, Nevada, 89502, 800-863-7515.

This Certificate of Coverage COC is provided to each Subscriber who has enrolled in PPHIC through a Group Contract. This COC, Summary of Benefits (SOB), Your enrollment form and identification card become the contract between You and PPHIC. By enrolling in PPHIC and accepting this COC, You agree to abide by the rules as described in this COC. This COC is provided upon enrollment, your renewal and upon request. Members are eligible to receive Medically Necessary Covered Services and Benefits described in this COC in exchange for the Premium paid to PPHIC. Please keep these materials handy so You can refer to them for information about Your Health Plan coverage.

The best way to take full advantage of Your Health Plan benefits is to familiarize Yourself with Your coverage. As a PPHIC Member, You are entitled to receive the services and benefits described in this COC. This booklet contains a description of the PPHIC benefits and services available to You. Information about Copayments, Coinsurance, Deductible and any applicable optional Group benefits which may be available to You are included in the Summary of Benefits (SOB) which has been supplied to the Subscriber.

The Subscriber is free to be treated by any Practitioner/ Provider he chooses. Whether or not the Practitioner/ Provider is an In-Network Practitioner/Provider will determine the amount of reimbursement. Please refer to Your Summary of Benefits (SOB) for Copayments, Deductibles, Coinsurance and limitations.

If You have questions about this COC), please call a PPHIC Customer Service Representative at 800-863-7515 or (TTY Operator Assistance) 800-326-6868.
Our website, www.prominencehealthplan.com, also serves as an important resource for your COC, provider directories, urgent care and emergency care locations and more.

For inquiries and complaints, Members may also contact the Nevada Division of Insurance.

State of Nevada Division of Insurance
Carson City Office:
Phone: 775-687-0700, Fax: 775-687-0787
Consumer Compliance & Licensing
Fax: 775-687 0797
1818 E. College Pkwy., Suite 103
Carson City, Nevada 89706

Las Vegas Office:
Phone: 702-486-4009, Fax: 702-486-4007
3300 W. Sahara Avenue, Suite 275
Las Vegas, Nevada 89102
Monday – Friday, 8 a.m. to 5 p.m.
Division of Insurance Toll Free: 888-872-3234

LANGUAGE TRANSLATION SERVICES
If you or someone you are assisting has questions about your health benefits or other information related to your plan coverage, you have the right to receive help and information in a language other than English at no cost. Please call Prominence Health Plan Customer Service at 800-863-7515 and they can assist you with access to language translation services. You can also contact Customer Service to ask for the translation of written benefit materials. TTY/TDD services are available by dialing 800-326-6868.

SECURE ONLINE MEMBER PORTAL
This information sheet is designed to provide Prominence Health Plan Members with step-by-step directions for creating a log-in and password to access secure online Member benefit information. The Health Information Portability and Accountability Act of 1996 ("HIPAA") protects patient privacy. This online benefit information service is HIPAA compliant.

System Features
- Check and view member eligibility
- Search or download Provider Directory
- Change PCP
- View member specific benefit information
- View claims
- Print Temporary ID Card
- Order ID Card

Current Members
To access the secure Online Member Portal, visit www.prominencehealthplan.com. If You have forgotten Your password, select "Forgot Your password?" and follow the screen prompts.

New User Registration
Before You begin, You will need Your Health Plan ID number located on Your identification card.
- Visit www.prominencehealthplan.com or www.prominencemember.com.
- Select "Create an account" and follow the prompts.

For Assistance
If You need assistance setting up Your login or password, please contact:

Prominence Health Plan Customer Service
800-863-7515
Monday through Friday, 8 a.m. to 5 p.m.

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Abbreviations Key

ADEA - Age Discrimination in Employment Act

COB - Coordination of Benefits

COC – Certificate of Coverage

COE - Center of Excellence

DME - Durable Medical Equipment

EME - Eligible Medical Expense

ERISA - Employment Retirement Income Security Act

ESRD - End Stage Renal Disease

FDA - U.S. Food and Drug Administration

HC – Health Choice

IPA - Independent Practice Association

NCQA - National Committee for Quality Assurance

OCHA - Office of Consumer Health Assistance

PHCN – Preferred Healthcare Network

PCP - Primary Care Provider

PHSA - Public Health Services Act

PPO – Preferred Provider Organization

QI - Quality Improvement

SOB - Summary of Benefits

TMJ – Temporomandibular Joint Disorder

TPN - Total Parenteral Nutrition

UM - Utilization Management

Para obtener asistencia en Español, llame al: 800-863-7515. Los avisos están también disponibles en Español a petición.

Part I. Definitions

1. **Accessibility -** The extent to which a Member of PPHIC can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment.
2. **Accident Injury -** Bodily injuries that are sustained as a direct result of an unintended, unanticipated event that is external to the body and that occurs while the injured person's coverage under the policy is in force; and which directly (independent of sickness, disease, mental incapacity, bodily infirmity or other cause) causes a covered loss. Bodily injuries include, but are not limited to, fractures, lacerations, burns, sprains ingesting poison and concussions.
3. **Acupuncture -** Is considered an Alternative Medicine and is the piercing of peripheral nerves with needles to relieve the discomfort of painful disorders and/or for therapeutic purposes. Service must be provided by a provider licensed by the State Board of Oriental Medicine.
4. **Acute -** An illness or injury of short duration and generally of sudden onset and infrequent occurrence.
5. **Adverse Benefit Determination -** Adverse determination means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.
6. **Alternative Medicine -** Approaches to medical diagnostic and therapy that have not been developed by use of generally accepted scientific methods. Forms of Alternative Medicine include acupressure, acupuncture, aroma therapy, ayurveda, biofeedback, herbal medicine, holistic medicine, homeopathy and hypnosis.
7. **Anniversary or Anniversary Date -** The annual date, every 12 months, upon which the coverage under this COC renews for another 12-month period.
8. **Anorexia Nervosa -** A condition characterized by a refusal to maintain a minimally normal body weight.
9. **Appeal -** A written request to PPHIC to change an Adverse Benefit Determination.
10. **Authorization -** The process by which an In-Network Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Plan Member and obtain approval from the Medical Plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment; payment is dependent upon eligibility at the time Covered Services are received.
11. **Authorized Representative** - A person to whom a covered person has given (a) express written consent to represent the covered person in an external review of an adverse determination; (b) A person authorized by law to provide substituted consent for a covered person; or (c) A family member of a covered person or the covered person's treating provider only when the covered person is unable to provide consent.
12. **Autism Spectrum Disorder -** A condition that meets the diagnostic criteria for Autism Spectrum Disorder published in the current edition of the "Diagnostic and Statistical Manual of Mental Disorders" published by the American Psychiatric Association or the edition of the Manual that was in effect at the time the condition was diagnosed or determined.
13. **Autism Behavior Interventionist -** A person who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of: a licensed psychologist; a licensed behavior analyst; or a licensed assistant behavior analyst.
14. **Availability** - The extent to which the Plan has In-Network Practitioners/Providers of the appropriate type and number distributed geographically to meet the needs of its membership.

15. **Balance Billing –** When a Provider bills You for the difference between the Provider's charge and the allowed amount. For example, if the Provider's charge is $50 and the allowable amount is $30, the Provider may bill You for the remaining $20. An In-Network Provider may not Balance Bill You for Covered Services.

16. **Bariatric Restrictive Services -** Includes various surgical interventions to accomplish weight-loss reduction in individuals who meet the criteria.

17. **Bulimia Nervosa -** A medical condition characterized by repeated episodes of binge eating followed by inappropriate compulsory behaviors such as self-induced vomiting, misuse of laxatives, misuse of diuretics, or other medications, fasting and or excessive exercise.

18. **Calendar Year -** The 12-month period beginning January 1 and ending December 31.

19. **Cardiac Rehabilitation Services** - Phase I and Phase II includes Inpatient cardiac monitored services; programs are physician ordered and supervised.

20. **Centers of Excellence (COE)** - An approved Center of Excellence (COE) is a health care facility or practitioner that provides highly specialized care to Prominence Members with certain health conditions. COE partner facilities or providers must meet PPHIC high standards for quality and value including demonstrated positive patient outcomes, cost-efficient health care delivery and compliance with rigorous quality control metrics.

    Members must be pre-approved to use a designated COE facility or practitioner. As designated COE providers may be located out of PPHIC Health Insurance Companies' primary service area, Members may be eligible for travel benefits. Members are required to use COE facilities approved for specific medical conditions or surgical procedures; a non-COE facility may be pre-approved by Prominence Utilization Management Department if a COE facility is unable to provide the required services.

    For more information about the COE program and all participating facilities, please visit www.prominencehealthplan.com.

21. **Certificate of Coverage COC -** This document, any Riders, the Summary of Benefits, and any amendments that may be added in the future, which explain the services and benefits covered by PPHIC and defines the rights, responsibilities and accountabilities of the Member and PPHIC.

22. **Chelation Therapy -** The treatment and removal of lead poisoning or other heavy metal poisoning from the body.

23. **Children under the Age of 26 -** The Affordable Care Act requires that dependent children be covered up to age 26.

24. **Chronic/Supportive** - An illness or injury that is or expected to be, six (6) months or longer, and/or with frequent recurrences and is always more or less present. Chronic/Supportive conditions may have Acute episodes.

25. **Coinsurance -** The percentage of charges billed or the percentage of eligible medical expense charges whichever is less that a Member must pay an In-Network Practitioner/Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the In-Network Practitioner/Provider who bills for the Covered Services.

26. **Complaint** - An oral or written expression of dissatisfaction from a Member or Practitioner/Provider.

27. **Complex Diagnostic Testing -** Diagnostic imaging and testing including, but not limited to PET Scans, Stress tests, Complex Echocardiography, Complex Duplex Scans, Sleep Studies, Seizure Monitoring, Complex Angiography, Complex Aortography, Complex Musculoskeletal imaging and SPECT scans. This category of imaging does not include screening and diagnostic mammography, x-ray, ultrasound, MRI and CT scans, and basic diagnostic testing.

28. **Compression Stockings -** Various graded stretch material to create compression.
29. **Congenital** - Existing at or dating from birth, acquired during development in the uterus.
30. **Contraceptive Methods -** All Food and Drug Administration (FDA) approved contraceptive methods prescribed by a women's doctor are covered.
31. **Coordination of Benefits (COB) -** A process by which another group health plan (if the Member is enrolled on both this PPHIC Plan and another group health plan) may be responsible for claims payment either as the primary or secondary carrier.
32. **Copayment -** The amount paid by You directly to the healthcare In-Network Practitioner/Provider at the time the services are received. These Copayments are described in the Summary of Benefits, a separate document, which is supplied to the Subscriber.
33. **Cosmetic -** Procedures which are performed primarily to improve or change physical appearance or bodily form, but which do not correct or materially improve a physiological function.
34. **Covered Services -** Those Medically Necessary medical and Hospital services described in this COC, which, for the purpose of preventing, alleviating, curing or healing illness or injury, are provided to Members.

    While Covered Services must always be Medically Necessary, not every Medically Necessary service is a Covered Service.
35. **CT Scan-** Computerized axial tomography scan is more commonly known by its abbreviated name, CT Scan. It is an x-ray that combines many x-ray images with the aid of a computer to generate cross-sectional views and, if needed, three-dimensional views of organs and structures of the body.
36. **Custodial Care -** Healthcare services or other related services which:
    a. Does not seek a cure;
    b. Are provided during periods when Acute care is not required or when the medical condition of a
    c. Member is not changing;
    d. Does not require continued administration by licensed medical personnel;
    e. Assists in the activities of daily living.
37. **Deductible** - A set amount of covered charges occurring each Calendar Year which must be paid by the Member before benefits are payable under this EOC. Copays do not count towards the deductible; copays do count towards the out-of-pocket maximum.
38. **Dental Injury -** An injury to Sound Natural Teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.
39. **Dependent -** Any Member of the Subscriber's family who meets the eligibility as defined in this COC and has been enrolled by the Subscriber.
40. **Developmental Delay -** When a Member has not reached the appropriate level of intellectual, speech, motor or physical development normally expected for the Members age, and such conditions are not a result of an injury or illness.
41. **Diagnostic Services -** Medically necessary tests performed to aid in the diagnosis or detection of disease. Diagnostic testing is essential to the basic management of patient care, allowing physicians to detect disease earlier, make diagnoses, prescribe therapies, and monitor results. Some diagnostic testing is considered Complex Diagnostic Testing.
42. **Disability** - The inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

43. **Domestic Partner -** A domestic partnership is a civil contract that grants domestic partners the same rights, protection, benefits, responsibilities, obligations and duties as do parties to any other civil contract.

44. **Durable Medical Equipment (DME)** - Equipment We determine to be:

    a. Designed and able to withstand repeated use;

    b. Used primarily and customarily for a medical purpose;

    c. Is generally not useful to a Member in the absence of an Illness or Injury; and d. Suitable for use in the home.

45. **Eligible Medical Expense (EME)** - The maximum amount PPHIC determines to be eligible for consideration as payment for a particular covered service, supply or procedure. For Out-of-Network services, the EME will be the lesser of the billed charge, the amount We would have considered for payment for the same service, supply or procedure were performed or provided by a PPHIC Provider or the Medicare reimbursement rate.

46. **Emergency Services -** Healthcare services that are provided to a member by a Practitioner/Provider after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity that a prudent person would believe the absence of immediate medical attention could result in: a) Serious jeopardy to the health of the member; b) Serious jeopardy to the health of the unborn child; c) Serious impairment of a bodily function; or d) Serious dysfunction of any body organ or part. Emergency services will be provided as:

    a. Without regard to whether the provider of the services is in-network;

    b. If the services are out-of-network, without administrative requirements or coverage limitations that are more restrictive than those imposed on in-network services; and

    c. Without regard to any other term or condition of the coverage, other than (1) the exclusion of or coordination of benefits; (2) an affiliation or waiting period permitted under ERISA, the PHSA, or the Internal Revenue Code, or (3) applicable cost sharing.

    d. If a Member receives services from an out-of-network provider, the provider is prohibited from collecting from a person covered by a policy of health insurance an amount for medically necessary services that exceeds the copayment, coinsurance, or deductible required by that policy.

47. **Employee** - A person who is designated as being eligible for coverage in the Group Enrollment Agreement and who meets all the applicable eligibility requirements of this Schedule of Covered Services, whose enrollment form has been accepted by PHF in accordance with the enrollment requirements of this Schedule of Covered Services and for whom premiums have been received by Prominence Preferred Health Insurance Company.

48. **Enteral Nutrition -** The delivery of nutrients by a tube into the gastrointestinal tract.

49. **Exclusion** - Any item or service which is not a Covered Service under this COC.

50. **Experimental/Investigational -** A drug, device, medical treatment or procedure that in PPHIC sole discretion meets any of the following:

    a. The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

    b. The informed consent document utilized with the drug, device, medical treatment or procedure indicates that such drug, device, medical treatment or procedure is experimental/investigational;

    c. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or

the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;

d. Unless otherwise mandated by State and Federal Statutes.

51. **External Review Organization -** Is a medical review performed by an independent review organization or specialist.

52. **Grace Period -** The 30-day period from the date Premium payment is due until it is considered delinquent. During the Grace Period coverage remains in effect.

53. **Group -** The employer or other party that has entered into a Group Contract with PPHIC through which this COC is made available to eligible employees, and the employer has agreed to collect and pay Premiums. The Group is not an agent of PPHIC, but is considered the plan sponsor.

54. **Group Contract -** The agreement between the Group and PPHIC through which the Health Plan coverage for eligible employees and Dependents is elected.

55. **Group Open Enrollment Period -** Those periods of time established by the Group and PPHIC during which eligible persons who have not previously enrolled with PPHIC may do so. The enrollment period will be established at least once every 12 months.

56. **Habilitative Services** - Health care services that help a person keep, learn, or improve skills and functioning for daily living. Services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and outpatient settings.

57. **Home Health Agency** - An agency that provides intermittent Skilled Nursing Services and other therapeutic Medically Necessary Covered Services in Your home when You are confined to Your home, and when coordinated by an In-Network Practitioner/Provider.

58. **Hospital -** An Acute Care Hospital licensed by the State and approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or by the Medicare program. A Hospital is not a government Hospital, a place for rest, a place for the aged, or a nursing home.

59. **Hospital Outpatient Facility** - This facility conducts testing and ambulatory procedures and is owned and/or operated by a hospital. An additional share of cost may be required when a Member chooses to receive elective care from a hospital outpatient facility.

60. **Independent Review Organization (IRO)** - An entity that: (a) Conducts an independent external review of an adverse determination; and (b) is certified by the Nevada Division of Insurance Commissioner to do so.

61. **In-network** - A term for providers or facilities that enter into a network agreement with PPHIC.

62. **In-network, free-standing, outpatient facility** - These facilities may provide lab tests, diagnostic tests, radiological testing, and other ambulatory procedures, but is independent from a hospital. These in-network facilities are usually the most cost effective option for a Member to receive diagnostic and radiological testing.

63. **Inquiry -** Any communication that has not been subject to an Adverse Benefit Determination and that requests concerning an action, a failure to act, or questions a Plan interpretation by PPHIC.

64. **Medical Director** - A physician designated by PPHIC to monitor appropriate utilization of healthcare services, and quality of care.

65. **Medically Necessary -** Covered Services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by Us or Our Designee, within our sole discretion.

    a. In accordance with Generally Accepted Standards of Medical Practice;
    b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your sickness, injury, mental illness, substance use disorder,

disease or its symptoms;

c. Not mainly for Your convenience or that of Your doctor or other health care provider; and
d. Not more costly than an alternative drug, services(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

66. Medical Supplies - Medical Supplies are routine supplies that are customarily used during the course of treatment for an Illness or Injury. Medical Supplies include, but are not limited to the following:

a. Catheter and catheter supplies - Foley catheters, drainage bags, irrigation trays;
b. Colostomy bags (and other ostomy supplies);
c. Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lambs wool pads, sterile solutions, ointments, sterile applicators, sterile gloves;
d. Elastic stockings;
e. Enemas and douches;
f. IV supplies;
g. Sheets and bags;
h. Splints and slings;
i. Surgical face masks; and
j. Syringes and needles.

While Covered Services must always be Medically Necessary, not every Medically Necessary service is a Covered Service.

67. Member - Any Subscriber or eligible enrolled Dependents entitled to benefits under this COC.

68. Never Events - Are services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. “Never Events” include, but are not limited to:

i. Serious preventable event - Air embolism
ii. Serious preventable death - Blood incompatibility
iii. Serious preventable event - object left during surgery
iv. Catheter-associated Urinary tract infections
v. Pressure (Decubitus) ulcers
vi. Vascular catheter - associated infection
vii. Surgical site infection - Mediastinitis after coronary artery bypass graft (CABG) surgery.

viii. Hospital - acquired injuries - Fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes.

69. **Non-Covered Services -** Those services excluded from coverage pursuant to this COC.

70. **Non-Participating Provider** - A provider defined as one of the following:

    a. A facility provider, such as a hospital that has not entered into an agreement with PPHIC;

    b. A professional provider, such as a physician, who has not entered in to an agreement with PPHIC; or

    c. Providers who have not contracted or affiliated with PPHIC's designated subcontractor(s) for the services they perform under this certificate.

71. **Observation** - Care usually completed in less than 24 hours. Observation may be appropriate when many hours are required for testing or re-evaluation to determine the patient's diagnosis of care needs.

72. **Orthotic -** Customized devices to support or supplement weakened or abnormal joints or limbs as defined by Medicare DME guidelines.

73. **Out-of-Network Services** - Those Medically Necessary Covered Services provided outside the Preferred Healthcare Network or Universal Health Network

74. **Out-of-Pocket Maximum -** The combined total expense paid by a Member in Coinsurance, Copays and Deductible for all Covered Services in a Calendar Year. It does not include: Any expenses for Covered Services in excess of eligible medical expense Charges; Expenses for which no benefits are payable by the Plan.

75. **Palliative Treatment** - Treatment used in an emergency to relieve ease or alleviate the acute severity of dental pain, swelling or bleeding. Palliative treatment usually is performed for, but not limited to, the following acute conditions:

    a. Toothache;
    b. Localized infection;
    c. Muscular pain; or Sensitivity and irritation of the soft tissue.
    Services are not considered palliative when used in association with any other covered services except X- rays and/or exams

76. **Participating Provider -** A facility provider (such as a hospital) or a professional provider (such as a physician) that has entered into an agreement with PPHIC to bill PPHIC directly for covered services, and to accept PPHIC maximum payment allowance for covered services.

77. **Pneumatic Compression Stockings** - The use of air to create compression.

78. **PPHIC –** Prominence Preferred Health Insurance Company, Inc.

79. **PPO Provider** - A participating facility provider or a participating professional provider that has entered into an agreement with PPHIC to limit charges for services performed under this certificate.

80. **Preferred Health Care Network (PHCN)** - A network of hospitals, physicians and other medical Providers participating as independent contractors.

81. **Premium** - The periodic payment, usually monthly, made to PPHIC by You, or on Your behalf, that entitles You to the benefits outlined in this COC.

82. **Preventive Care Services** - Preventive Care Services including, physician exams, preventive screens (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services and HIV testing), and additional preventive care for women provided for in the guidelines supported by the U.S. Preventive Services Task Force. This list is

not exhaustive. This benefit includes all Preventive Care Services required by federal and state law - see the list at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care.

83. **Primary Care Provider (PCP)** - A medical professional who assists a Member in identifying, preventing or treating an illness, injury or disability. Plan Members have the right to designate any primary care provider who is a participating provider and who is available to accept you or your family members.

    For information on how to select a primary care provider, and for a list of the participating primary care providers, please call a Prominence Customer Services Representative at 775-770-9312 or 800-863-7515.

    For children, a Member may designate a pediatrician as the primary care provider.

84. **Prior Deductible Credit** - When Members change to an PPHIC employer health coverage from another health insurance carrier's employer coverage, they may be eligible for prior in-network deductible credit upon initial enrollment. Prior deductible credit is the term used when claims for services or supplies that were applied toward the current deductible requirement of the prior carrier are applied to the deductible requirement of the PPHIC Coverage. Members must request prior deductible credit and submit written notification of such charges to PPHIC's Customer Service department no later than 180 days following the employer's effective date with PPHIC.

85. **Prior Authorization** - The process in which an In-Network Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Plan Member and obtain approval from the Plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment: payment is dependent upon eligibility at the time Covered Service is received. For a complete list of services requiring an authorization visit our website at www.prominencehealthplan.com A Member does not need prior authorization from the Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specialize in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact PPHIC Customer Service at 775-770-9312 or 800-863-7515, or www.prominencehealthplan.com.

86. **Professional Services -** Those Covered Services, except as excluded or limited in this Certificate of Coverage, performed by physicians and health professionals who are Medically Necessary and generally recognized as appropriate care within the Service Area and in accordance with PPHIC policies and procedures. Covered Services includes Telemedicine health care providers.

87. **Prosthetic** - That which replaces all or part of an internal or external body organ (including contiguous tissues) or replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ as defined by Medicare DME guidelines. Artificial organs including but not limited to, artificial heart and pancreas are not considered corrective appliances.

88. **Provider Directory** - Is a list of PPHIC In-Network Practitioners/Providers that provide Medically Necessary Covered Services to all Members. The Provider Directory can be provided upon enrollment, upon group renewal, upon request and at www.prominencehealthplan.com. The Provider Directory is provided to the Subscriber at the time of enrollment to assist Members with their selection of provider for their healthcare services. Additions and changes are continuously made to the Provider Directory; therefore, to confirm a Practitioner's or Provider's participation with PPHIC contact Customer Service at 800-863-7515 prior to receiving services. It should be noted that the Provider Directory represents a list of Practitioner's which Prominence has a contractual relationship for the provision of medical services, but this list does not imply an employer/employee relationship between Prominence and the Practitioners.

89. **Qualifying Coverage** - Benefits or coverage provided by Medicare or Medicaid, or a plan of health insurance or health benefits which provides basic medical and Hospital care including, without limitations, emergency care, inpatient and outpatient Hospital services, physician services, outpatient medical services, laboratory and x-ray services.

90. **Refraction -** The act of determining the nature and degree of the refractive errors in the eye and correction of the same by lenses.

91. **Rehabilitative Therapy** - Physical, speech, occupational, cardiac, and pulmonary/respiratory therapy.

92. **Rescissions** - The Plan will not terminate or rescind coverage once a Member is enrolled unless the individual (or person seeking coverage on behalf of the individual) performs an intentional act, practice or omission that constitutes fraud, or unless the individual makes an intentional material misrepresentation of fact as prohibited by the terms of the Certificate of Coverage. The Plan will provide at least 30 days advance written notice to each Member who would be affected before Plan Coverage will be rescinded.

93. **Residential Treatment/Care** - Treatment of medical, mental or chemical dependency disorders including eating disorders, on an inpatient and outpatient basis by an accredited/licensed facility/ program with onsite housing/dormitory accommodations, and onsite day treatment programs.

94. **Retirees -** One who has retired from active work.

95. **Self-Directed -** Those Services a Member elects to Self-Direct to an Out-of-Network Practitioner/ Provider.

96. **Self-injectable -** Any medication that can be given by the sub-cutaneous or intra-muscular route (excluding insulin) is considered a self-injectable. Self-injectable does not refer to the fact that the medication is given by a Member to him/herself, but rather that the route of injection is not intravenous and does not normally, therefore, require a specialized setting and/or extensive medical surveillance.

97. **Short Term Therapy -** Therapy that is limited to treatment for conditions which are subject to significant clinical improvement within the period of time defined in this COC.

98. **Skilled Nursing Care** - Services that can only be performed by, or under the supervision of, licensed nursing personnel.

99. **Skilled Nursing Facility** - A facility which is licensed by the State to provide inpatient medical and nursing care, and is recognized as such by Medicare. Care in a Skilled Nursing Facility is provided only if Hospitalization would otherwise be required. The term Skilled Nursing Facility does not include a convalescent nursing home, rest facility, or facility for the aged.

100. **Sound Natural Teeth** - Teeth which:

    a. Are whole or properly restored;
    b. Are without impairment or periodontal disease; and
    c. Are not in need of the treatment provided for reasons other than Dental Injury.

101. **Specialty Drugs** - includes self-injectables and medications given by or other routes of administration. Specialty Drugs require the coinsurance listed on Your Summary of Benefits (SOB). Self-Injectables include combination therapy kits, which can be obtained from an outpatient pharmacy, and can be self-administered. Insulin is not considered a Specialty Drug. The list of Specialty Drugs can be found on the Prominence Health Plan website at www.prominencehealthplan.com. Contact Customer Service for more information.

102. **Specialty Pharmaceuticals** - Some Specialty Drugs require the Member to obtain the drug through the PPHIC's Specialty Drug provider. Contact Customer Service for more information. Some Specialty Drugs will be limited to 30 day supplies.

103. **Specialist -** a physician other than a Primary Care Provider who is participating in PPHIC and listed in the current Provider Directory. A Specialist should only be seen when coordinated by an In-Network Practitioner/Provider and may require Prior Authorization by PPHIC except in the case of Emergency Services.

104. **Subscriber -** A person who meets all eligibility requirements and has completed an enrollment form, has completed a health assessment form and/or provides certificate of creditable coverage, and has paid, or

have paid on his or her behalf, all applicable Premiums. The Subscriber is the person to whom this COC is issued.

105. **Summary of Benefits (SOB)** - The summary of Covered Services, benefit limitations, Coinsurance (if applicable), and Deductibles that are provided to the Group.

106. **Telemedicine Services** - A delivery of healthcare services from a provider of healthcare to a patient at a different location through the use of technology that transfers information electronically, telephonically or by fiber optics, not including standard telephone, facsimile or electronic mail. The Provider must hold a valid license or certificate to practice his or her profession in this State.

107. **Total Parenteral Nutrition (TPN)** - The delivery of nutrients through an intravenous line directly into the blood stream.

108. **U.S. Food and Drug Administration (FDA)** - Protecting the public health by assuring that foods (except for meat from livestock, poultry and some egg products which are regulated by the U.S. Department of Agriculture) are safe, wholesome, sanitary and properly labeled; ensuring that human and veterinary drugs, and vaccines and other biological products and medical devices intended for human use are safe and effective.

109. **Urgent Care Services** - Care for Medically Necessary Covered Services due to injury, illness or another type of condition, usually not life threatening, which should be treated within 24 hours. Routine or follow-up care is not considered an Urgent Care Service.

110. **Waiting Period** - The length of time a Member must continuously work for the Group before the Member is eligible for coverage.

111. **We or Us** - Refers to Prominence Preferred Health Insurance Company, Inc.

112. **Workers Compensation -** With respect to any injury or illness means any injury or illnesses arising out of or in the course of employment for pay or profit.

113. **You or Your** - Refers to You, Subscriber/Member, and Your eligible enrolled Dependents (Members).

Part II. Patient Protection and Affordable Care Act Changes Impacting Group Health Plans

1. **Access to Obstetrical or Gynecological Care** - A Plan Member does not need prior authorization from the Plan or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact PPHIC Customer Service at 775-770-9312 and 800-863-7515.

2. **Guidance on Rescissions** - The Plan will not rescind coverage once a Member is enrolled unless the individual (or a person seeking coverage on behalf of the individual) performs an intentional act, practice or omission that constitutes fraud, or unless the individual makes an intentional material misrepresentation of fact, as prohibited by the terms of the Certificate of Coverage. The Plan will provide at least 30 days advance written notice to each individual who would be affected before coverage will be rescinded.

3. **Coverage of Preventive Health Services** - The Plan provides preventive services such as mammograms, colonoscopies, cancer screenings, blood pressure and cholesterol tests, counseling to lose weight or quit smoking, health check-ups, and immunizations for children without cost-sharing by Members. Preventive Health Services provided without cost-sharing include:
   a. Services recommended by the U.S. Preventive Services Task Force;
   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;
   c. Preventive Care and Screenings for infants, children and adolescents supported by the Health Resources and Services Administration;
   d. Preventive Care and Screenings for women supported by the Health Resources and Services Administration.

Part III. Advance Directives: Making Your Healthcare Wishes Known

Prominence Preferred Health Insurance Company, Inc. (PPHIC) is required by law to inform Your of Your right to make healthcare decisions as well as Your right to execute advance directives.

An advance directive is a formal document written by You in advance of an incapacitating illness or injury. As long as You can speak for Yourself, PPHIC Providers will honor Your wishes. If You become so sick that You cannot speak for Yourself, then this advance directive will guide Your healthcare providers in treating You and will save Your family, friends and Practitioners from having to determine what You would have wanted.

There may be several types of advance directives You can choose from, depending on State law. Most states recognize:

1. Durable Power of Attorney for Health Care;
2. Living wills; and
3. Natural Death Act Declarations

You can purchase forms from a stationery store or request a form from Your Primary Care Provider or they are also available on our secure member website at www.prominencehealthplan.com. They are available in English and Spanish. Alternatively, You may wish to speak with Your attorney.

You should provide copies of Your completed directive to:

1. Your Primary Care Provider;
2. The person designated as Your agent for making healthcare decisions; and
3. Your family

Be sure to keep a copy with You and take a copy to the Hospital when You are hospitalized for medical care. You are not required to initiate an advance directive, and You will not be denied care if You do not have an advance directive.

If You believe Your Contracted In-Network Practitioner/Provider has not complied with Your advance directive, You may file a Complaint with the State of Nevada Health Division.

The Provider Order for Life-Sustaining Treatment (POLST) form is a concise medical order completed by a person's Physician, APRN or a Physician's Assistant after a discussion to determine which treatments the patient wants and does not want near the end of life. The form is printed on bright pink paper and signed by both a Provider and patient, POLST helps give seriously ill patients more control over their end-of-life care. The POLST form complements an Advance Directive and is not intended to replace any type of AD. For more information on POLST, visit www.nevadapolst.org.

Part IV. Utilization Management and Quality Improvement Programs

1. Utilization Management Program

The purpose of the Utilization Management (UM) Program is to maximize the effectiveness of services provided to Plan Members by advocating access to appropriate, quality and cost-effective care. Utilization Management involves the assessment, evaluation, planning and coordination of healthcare services for a culturally diverse population. The Comprehensive Utilization Management promotes objective, systematic monitoring and evaluation of appropriate resources throughout the continuum of care.

Key components of Utilization Management (UM) include Prior Authorization, concurrent review (while You are receiving inpatient care) and retrospective review and case management. The Utilization Management staff works under the direct supervision of the Plan Medical Director. Prominence Health Plan believes there is special concern regarding under-utilization. Utilization Management review decisions are based only on appropriateness of care, services requested and existence of benefit coverage. PPHIC does not incentivize Practitioners/Providers or other individuals conducting utilization review for denials of coverage or service, nor does it provide financial incentives to those reviewing the cases to encourage denial determinations. Utilization Management staff provides telephonic coverage from 8 a.m. - 5 p.m. (normal business hours) Monday – Friday (normal business days), for callers with questions about the UM process. A toll- free number (800) 863-7515 for inbound callers with questions about the UM process is also available. Referrals are not necessary to see clinical specialists but tests and procedure orders by the specialist may require prior auth.

Prior Authorization review includes eligibility verification, benefit interpretation and administration and Medical Necessity review of both in-patient/out-patient services. Requests for services requiring Prior Authorization are reviewed and determinations made by the appropriate licensed Utilization Management personnel.

Concurrent review is an assessment of ongoing medical and behavioral health services to determine continued medical necessity and appropriateness of care. Concurrent and retrospective review is performed for all known admissions to healthcare facilities (Acute Hospital Rehabilitation, Skilled Nursing and Behavioral Health Facilities) and care provided by Home Health Agencies. Discharge Planning is provided to assist patients with needs outside the healthcare facility setting.

Coordination is a collaborative process which coordinates and evaluates the options and services to meet an individual's health needs. Complex Care Coordination is a systemic assessment of care and services to Members with complex needs. Assistance with care transitions is provided through the plans in-patient discharge call campaign, which provides the PCP with patient encounter information after discharge. Care Coordination/Case Management will assist in the process of identifying Members who may benefit from Population/Disease Management or Complex Case Management for those Members with multiple complex medical conditions. Case management can provide assistance in assuring continuity and coordination of care by providing assistance with referrals to appropriate contracted Centers of Excellence, tertiary and transplant care.

Members may self-refer for Care Coordination, and Complex Case Management. There is no cost to participate and Members may opt out at any time.

Technology assessment and guidelines review and evaluate new and/or changes in technologies relating to procedures, pharmaceuticals, devices, diseases and preventive services. Evidence based evaluations are reviewed and recommendations developed regarding benefit determinations based on a rational approach to the use of technology to improve the healthcare of Plan Members.

Complex Care Coordination/Care Coordination is offered by PPHIC at Prominence PPHIC's discretion and is provided by Registered Nurses. This process assists members who have complex medical, psychosocial and care coordination needs.

Care Coordinators/Case Managers provide needed information and education to promote understanding, of the plan of care benefits available and resource utilization. This can help reduce the chance of further complications, and facilitate efficient and appropriate delivery of care and services.

Contacting Utilization Management: If You have any questions or wish to make a referral to Care Coordination/Case Management, please call our Central Intake line at 833-201-0303, Monday-Friday, excluding holidays.

2. Care Coordination Services

General Care Coordination and Disease Management programs are available. They include: Care Coordination can assist Members whose benefits are ending by providing alternatives and resources for continuing care and how to obtain it as appropriate. Care Coordinators can assist pregnant adolescents in their transition from Pediatrics to an Adult Primary Care Provider, OB/GYN, Family Practitioner or Interventionist.

Care Coordinators can also assist those Members reaching adulthood and have not chosen an Adult Primary Care Physician and helping them select an Adult Primary Care Provider.

3. Quality Improvement Program

PPHIC Quality Improvement (QI) Program is designed to assess and improve the quality of care and service delivered to Medical Plan Members. The goal of the QI Program is to monitor the quality and appropriateness of patient care and service and to meet or exceed established local, State and national standards. Methods to achieve this include, but are not limited to, establishing standards and performance goals for the delivery of care and services, measuring performance outcomes and development and implementation of action plans to improve outcomes.

The focus of the QI Program is to improve the overall health status of Medical Plan Members through systematic identification and review and evaluation of processes to achieve improvement. An appropriate balance between quality and quantity of health care will be achieved through a system of formalized objective evaluations. The comprehensive QI Program provides the framework for determining indicators for recommended levels of care and service. Opportunities for improvement are selected through the monitoring of identified quality and performance indicators.

The Utilization Management, Health Management and Quality Improvement operational functions are under the direct supervision of the Plan Medical Director and Chief Medical Officer, respectively.
Quality Improvement functions in conjunction with the Health Plan Organizational Structure and the Quality Improvement Committee and subcommittee structures to promote appropriate system development and implementation to meet the requirements of Members, employers, employees and the In-Network Practitioner/Provider network.

Additional information regarding the Utilization Management and/or the Quality Improvement programs is available by accessing Prominence Health Plan website at www.prominencehealthplan.com or call Customer Service at 800-863-7515.

4. Affirmative Statement Regarding Incentives

Prominence Health Plan distributes annually an affirmative statement regarding incentives to all members and to all practitioners, providers and employees who make utilization management decisions, affirming the following:

1. Utilization Management (UM) decision-making is based only on appropriateness of care and services and existence of coverage.

2. The organization does not specifically regard practitioners or other individuals for issuing denials of coverage or service care.

3. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization. Incentives, including compensation, for any person are not based on the quantity or type of denial decisions rendered.

Part V. Eligibility, Enrollment and Effective Date of Coverage

1. Eligible Employees

a. To be eligible to enroll as a Subscriber You must:
   i. Work the regularly scheduled number of hours for coverage as designated by the Group in the Master Group Application;
   ii. Be an eligible employee of the Group entitled to participate in the healthcare benefit program arranged by the Group or be entitled to coverage under a trust agreement or employment contract; and;
   iii. Satisfy any probationary or Waiting Period requirements established by the Group and enroll within 31 days of Your eligibility date.
   iv. Complete a health assessment form and/or provide a certificate of creditable coverage.

b. To be eligible for retiree medical benefits you must:
   i. Be an active Member entitled to benefits under this COC up to the time of your retirement;
   ii. Meet the eligibility requirements for retiree medical coverage as designated by your Group in the Master Group Application; and
   iii. If you or your spouse is eligible for Medicare Part A & B, you must enroll in Medicare Parts A & B.

c. Employees who refuse coverage for any reason and later decide they want coverage, will not be eligible until the next Group Open Enrollment Period. However, the employee may revoke a coverage election if one of the following qualifying events has occurred within 31 days of the qualifying event and they are adding newly eligible Dependents:
   i. Marriage;
   ii. Death of Spouse;
   iii. Divorce or annulment;
   iv. Legal separation;
   v. Birth;
   vi. Adoption or placement for adoption;
   vii. Death of dependent child;
   viii. Newly eligible dependents due to plan design change;
   ix. Loss of coverage;
   x. Dependent status change;
   xi. Employment status change;
   xii. Judgement decree or order requiring coverage;
   xiii. Change in residence

   Enrollment form must be completed and received by PPHIC within 31 days of the qualifying event.

d. If an employee refuses coverage at the time of enrollment because they had other Qualifying Coverage, they will be eligible to enroll if one of the following has occurred:
   i. Employee is no longer eligible for benefits under the other Qualifying Coverage;
   ii. Expiration of COBRA continuation coverage;
   iii. Termination of employment causing termination from the other Qualifying Coverage;
   iv. Reduction of the number of hours of employment, resulting in termination of the other Qualifying Coverage;
   v. Employer contributions toward other Qualifying Coverage terminated; or
   vi. Death or divorce of a spouse resulting in the termination of the other Qualifying Coverage.

   In order to be eligible to enroll as a result of one of the above Qualifying Coverage events, PPHIC must receive an application for enrollment and within 31 days of the date of the Qualifying Coverage event. Once PPHIC receives proof of previous Qualifying Coverage, the enrollment form, and the Employee will be effective retroactively to the day following the loss of the Qualifying Coverage.

2. Eligible Dependents

a. To be eligible to enroll as a Dependent the person must:

i. Be the Subscriber's legal Spouse;
ii. Be the Subscriber's Domestic Partner and hold a Certificate of Registered Domestic Partnership per NRS 122A. If partnership was validly formed in another jurisdiction, then domestic partnership will be recognized without Certificate of Registered Domestic Partnership**;** (unless specifically excluded by the employer)
iii. Be a married or unmarried child under the age of 26. The term "child" includes natural children, stepchildren, eligible foster children, and children for whom You have been appointed by the courts as permanent legal guardian, or children who have been legally adopted or are awaiting finalization of adoption by You, The child does not have to reside with the parent; or
iv. Be an unmarried child who is and continues to be both (1) medically certified as mentally or physically disabled and (2) dependent upon the Subscriber of the insured Group for support and maintenance. This condition must have occurred before the child reaches age26. Proof of this incapacity must be furnished to Prominence HealthFirst within 31 days after such Dependent attains age 26 and then once a year beginning two years after the Dependent has reached the age of26. Prominence HealthFirst will require a completed Dependent Disability Verification form, provided by Prominence HealthFirst, and evidence that the dependent is declared to be financially dependent on the Subscriber's tax documents. The child does not have to reside with the parent

b. Eligibility for Dependents of Retirees
   i. To be eligible to enroll as a dependent of a retiree, a retiree must be a Member entitled to retiree medical benefits under this EOC.
   ii. Dependent children include a retiree's natural children, legally adopted children, children for whom the retiree acts as the legal guardian, step children who are dependent on the retiree for support, and children for whom the retiree acts as the proposed adoptive parent from the date of placement. Dependent children are eligible for Prominence HealthFirst plan benefits until age 26, unless otherwise covered by other employer provided health plan coverage.
c. Employees who refuse coverage for their Dependents, for any reason, and later decide they want coverage will not be eligible until the next Group Open Enrollment Period. However, if a Dependent refuses coverage at the time of enrollment because they had other Qualifying Coverage, they will be eligible to enroll if one of the following has occurred:
   i. Dependent is no longer eligible for benefits under the other Qualifying Coverage;
   ii. Expiration of COBRA continuation coverage;
   iii. Termination of employment causing termination from the other Qualifying Coverage;
   iv. Reduction of the number of hours of employment, resulting in termination of the other Qualifying Coverage;
   v. Employer contributions toward other Qualifying Coverage terminated; or
   vi. Death or divorce of a spouse resulting in the termination of the other Qualifying Coverage for Dependent children.

   In order to be eligible to enroll as a result of the above Qualifying Coverage events, PPHIC must receive an application for enrollment and within 31 days of the date of the Qualifying Coverage event. Once PPHIC receives proof of previous Coverage and the enrollment form, the Dependent will be effective retroactively to the day following the loss of the Qualifying Coverage.
d. Newborns of enrolled employees will be covered from the date of birth for 31 days, upon notification. Coverage is provided without premium for 31 days from birth. Coverage after the 31st will be provided only if the newborn is enrolled within 31 days from the date of birth.
e. Adopted or placed Dependents will be covered as of the date the adoption becomes effective or the date the child is placed in the home, whichever occurs first. An enrollment form and, if applicable, a health questionnaire must be completed and received by PPHIC within 31 days of the event. Certification by the adoption or placement agency will be required.

ii. Marriage, remarriage and/or newly acquired Dependents (e.g., stepchildren) will be covered only if an enrollment form and, if applicable, a health questionnaire is completed and received within 31 days from the date of marriage.
iii. Request for birth certificates, marriage license, court orders, or other items (e.g., Certificates of Coverage, US citizenship) must be furnished by the Member to PPHIC within 31 days of receipt of the request. Failure to furnish the requested documents will result in ineligibility
iv. Non-eligible Dependents are defined as persons to include, a child placed in the Subscriber's home (except those placed for adoption), a grandchild of Subscriber or Subscriber's spouse, an emancipated minor (as defined by Nevada law), legal wards (except those legal wards permanently placed in Subscriber's home by court order), and individuals whom You are the authorized power of attorney as appointed by the courts. Parents and/or relatives of the Member or Member's spouse are not considered eligible Dependents.

3. Enrollment

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment by PPHIC because of health condition, age, need for health services.

a. Initial Enrollment: As an employee of the Group, You are entitled to apply for coverage for Yourself and Your eligible Dependents during the initial Group Open Enrollment Period. All persons included for coverage must be listed on the provided enrollment form and, if applicable, a health questionnaire.
b. Group Open Enrollment: A Group Open Enrollment Period shall be held for at least 15 days once every 12 months at which time You or your eligible dependents may enroll as a Subscriber and/or a Member of PPHIC.
c. Notice of Ineligibility: It is Your responsibility to notify PPHIC of any changes which affect Your eligibility or the eligibility of Your Dependents within 31 days of the event.
d. Limitation: Persons initially or newly eligible for enrollment who do not enroll within 31 days of eligibility may only be enrolled during the next Group Open Enrollment Period, unless a Qualifying Coverage event occurs.

4. Effective Date of Coverage

After PPHIC receives a completed enrollment form, a health questionnaire (if applicable) and the appropriate Premium arrangements are made, coverage under this COC shall begin on the earliest of the following dates:

a. Initial Enrollment and Open Enrollment: Coverage shall begin on the date agreed upon by the Group and PPHIC.
b. Newly Eligible Employees: Coverage will become effective on the Group's eligibility date.
c. Newly Eligible Dependents: Coverage will begin as of the date of the event such as marriage, adoption, or guardianship, ONLY if the enrollment form and, if applicable, a health questionnaire is received within 31 days from the date of the event. Newly eligible Dependents not added within the 31 days, may not be added until the next Group Open Enrollment Period, unless a Qualifying Coverage event occurs.
d. The effective date of coverage as noted in 1. and 2. above, may be changed by agreement of the Group and PPHIC.
e. PPHIC will provide You with a COC and other Member materials upon enrollment.

Copayments, Coinsurance, and/or Deductible payments required for Medically Necessary Covered Services must be made to the In-Network Practitioner/Provider at the time services are received. Refer to the Summary of Benefits for Your schedule of Copayments, Coinsurance, and Deductible.

Part VI. Services and Benefits

1. Allergy Care

a. Coverage is provided for allergy testing, evaluation and for the preparation of allergy serum and shots.
b. Pediatric adolescent nebulizers are covered for home and school.

1. Alternative Medicine (Homeopathy, Acupuncture, Integrated Medicine)

a. Homeopathic treatment, Acupuncture and Integrated Medicine will be covered when medically necessary.
b. All herbal medications and/or over the counter products are not covered.
c. For coverage limitations, consult Your SOB.

2. **Ambulance Services**

Non-emergency

a. Ground ambulance services: medically necessary ambulance services provided within the service area and arranged in advance by an In-Network Practitioner/Provider and Prior Authorized by Prominence Preferred Health Insurance Company for the medical necessity of transporting You from one facility to another facility.
b. Air ambulance services: medically necessary ambulance services provided within the service area only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Must be arranged in advance by an In-Network Practitioner/ Provider and Prior Authorized by Prominence Preferred Health Insurance Company for the medical necessity of transporting You from one facility to another facility.
c. A $25,000 per trip maximum coverage limitation applies to out-of-network providers.

Emergency

a. Ground ambulance services: medically necessary ambulance services provided within the service area when the ambulance is ordered for an emergency that could jeopardize Your health. Ambulance service will be covered when ordered by an employer, school or public safety official, or when You are not in a position to refuse the service. This excludes ambulance services for work-related injuries or illness or Non-Covered Services even if determined to be Medically Necessary.
b. Air ambulance services: medically necessary ambulance services for emergency transport is covered to the nearest hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and must be verified by the records of the physician who treats you and by the ambulance company.
d. A $25,000 per trip maximum coverage limitation applies to out-of-network providers.

3. Clinical Trial or Study

This benefit applies only if there is no evidence based medical treatment available that is considered more appropriate than the treatment provided in the clinical trial as determined by PPHIC. Medical treatment under this provision must be provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome, if;

a. Clinical trial or study must be approved by:
   i. An agency of the National Institute of Health as set forth in 42 U.S.C. section 281(b);
   ii. A cooperative group;
   iii. The (FDA) as an avocation for a new investigational drug;
   iv. The United States Department of Veterans Affairs; or
   v. The United States Department of Defense.

4. **Cochlear Implants and Hearing Aids**

a. Prosthetic cochlear implant is covered only for children 12 and under with Congenital postlingual, profound, bilateral deafness who receive limited or no benefit from hearing aids. Benefit is limited to one per Member per lifetime.

b. Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Practitioner. Limited to (1) one item per three years. Limited to a single purchase. Repairs and replacements limited to once every three years.

5. **Continuity of Care Resulting from Termination of Network Provider**

If an insured is receiving medical treatment for a medical condition from a provider of health care whose contract is terminated during the course of the medical treatment, the policy will permit the insured to continue to obtain medical treatment for the medical condition from the provider of health care if the insured is actively undergoing a medically necessary course of treatment; and the provider of health care and the insured agree that the continuity of care is desirable. The coverage provided under Continuity of Care will be provided until the later of:

a. The 120th day after the date the contract is terminated; or
b. If the medical condition is pregnancy, the 45th day after:
   i. The date of delivery; or
   ii. If the pregnancy does not end in delivery, the date of the end of the pregnancy.

7. Contraception and Sterilization

a. Food and Drug Administration (FDA) approved oral contraceptive pharmaceuticals, Intrauterine device (IUD), Diaphragm and NuvaRing. Implants are also covered - refer to the Formulary.
b. FDA approved contraception and contraceptive Counseling
c. FDA approved sterilization procedures - services, treatment and procedures to induce voluntary elective sterilization.

8. Dental Care Services

Dental Care Services permitted under the medical plan include:

a. Treatment for accidental dental injury to Sound Natural Teeth, the jawbones, or surrounding tissues. This does not include tooth breakage while chewing. Treatment and repair must begin within 6 months of the date of a documented injury and may require Prior Authorization.
b. Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth.
c. Use of an outpatient or inpatient facility for dental procedures/services may be covered using the following criteria.
   i. Anesthesia/Facility Coverage
      01. The Member must have a diagnosed medical or behavioral condition, which requires outpatient hospitalization or general anesthesia when dental care is provided.
      02. Services must be provided by a designated contracted facility and anesthesiologist.
      03. May require Prior Authorization.
   ii. For coverage limitations, please consult your SOB and Prior Authorization list.
d. Dentures and bridges are not a covered benefit for any condition or diagnosis.
e. Orthognathic surgery is the surgical correction for congenital malposition of the bones of the jaw; the mandible, maxilla or both. The abnormality may be congenital, developmental or the result of disease. Orthognathic surgery may be considered Medically Necessary when non-surgical therapies fail and when Prominence Health Plan's Technological Assessment Policy for Orthognathic surgery is met. Prior Authorization may be required and coverage is limited.
   i. For coverage limitations, consult Your SOB and Prior Authorization list.
f. Appliance therapy that does not permanently alter tooth position, jaw position or bite relationship. The benefit for appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair and replacement of the appliance. Dental orthotics or appliances including, but are not limited to, oral appliances and night guards. Note: Night guard appliances are not subject to the Temporomandibular Joint Disorder (TMJ) benefit limits.

g. Temporomandibular Joint Disorder (TMJ): Covered services for any jaw joint problem, including TMJ disorder, craniomandibular disorder, head and neck neuromuscular disorder, or other conditions of the joint linking the jaw bone and skull include only medical services. Services or supplies recognized as dental procedures or supplies, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints, are not covered.
    i. Medical or surgical services related to TMJ disorder are covered. Services must be provided by an In-Network Practitioner/Provider.
    ii. A single examination including a history, physical examination, muscle testing, range of motion measurements and psychological evaluation, as necessary;
    iii. Diagnostic x-rays and in some instances second opinions may be required;
    iv. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is received on the same date of service; and
    v. Therapeutic injections.

   The following are not Covered Services for TMJ:
    i. CT Scans or magnetic resonance imaging (MRI) except in conjunction with surgical management;
    ii. Electronic diagnostic modalities;
    iii. Occlusal analysis;
    iv. Any procedure not specifically listed as a Covered Service.

h. Failure of the Member to comply with the requirements of the Utilization Management Department will result in a reduction of benefits.

9. Dermatology

The removal of benign skin lesions including seborrheic keratosis, sebaceous cysts, acquired or small (less than 1.5 cm) congenital nevi (moles), dermatofibromas (skin tags) and pilomatrixomata (skin tumors associated with hair follicles), or other benign skin lesions are considered medically necessary if any of the following criteria are met:

Biopsy or clinical appearance suggests or is indicative of pre-malignancy or malignancy

a. Due to its anatomic location, the lesion has been subject to recurrent trauma
b. Lesion appears to be malignant or pre-malignant (e.g. actinic keratoses, Bowen's disease, dysplastic lesions, lentigo maligna, or leukoplakia) or malignant (due to coloration, change in size or appearance, family history or patient history of melanoma)
c. Skin lesions are causing symptoms (e.g. bleeding, burning, itching or irritation)
d. The lesion has evidence of inflammation (e.g. edema, erythema, or purulence)
e. The lesion is infectious (e.g. warts)
f. The lesion restricts vision or obstructs a body orifice.

In the absence of any of the above indications, removal of benign skin lesions is considered cosmetic

10. Diabetic Supplies and Services

a. Coverage is provided for insulin and insulin syringes, diabetic blood or urine test strips, and lancets. Each item requires a separate prescription and is limited to a month supply. A copayment applies per 100 strips. This benefit only applies if You do not have a pharmacy Rider or other pharmacy coverage and must be coordinated by an In-Network Practitioner/Provider and obtained from a Plan pharmacy.
b. Routine foot care.
c. Diabetic custom-made shoes and/or foot orthotics for diabetics are covered at two pair per Member per Calendar Year up to a combined and must be prescribed by a physician.
d. Routine retinal examination which does not include the determination of Refraction.
e. For coverage limitations, consult Your SOB and Prior Authorization list.

11. Durable Medical Equipment

Durable Medical Equipment (DME) is medical equipment which can stand repeated use, is primarily and usually used to serve a medical purpose and is generally not useful to You in the absence of illness or injury.

a. Coverage is provided for DME as prescribed and must be coordinated by an In-Network Practitioner/Provider and may require Prior Authorization by PPHIC.
b. DME must meet the Medicare, and/or industry accepted standards and must be provided as a result of Medical Necessity and not be solely for convenience.
c. Repair, replacement and maintenance of covered DME is limited to normal wear, tear and growth change. There is no coverage for equipment which has been abused, stolen or improperly cared for; or for equipment solely for the purpose of travel.
d. Lymphedema Treatment: No more than two (2) pair of pneumatic compression garments are covered per calendar year.
    i. Compression stockings: No more than four (4) pair of individually fitted prescription graded compression stockings with more than 18 mm Hg are covered per calendar year.
e. For coverage limitations, consult Your SOB and Prior Authorization list.

12. Eating Disorders

a. Inpatient admission or partial hospitalization, including residential treatment, for the diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating disorders not otherwise specified and refer to the Summary of Benefits.
    i. Services must include medical supervision, including but not limited to, nutritional counseling and psychosocial counseling;
    ii. Facility must be appropriately accredited and/or licensed.
b. Medical Nutrition Therapy
    i. Coverage provides Medically Necessary Medical Nutrition Therapy/Nutritional Counseling, with PCP/Physician referral, limited to 25 visits per calendar year* for medical necessity: Diabetes, Obesity (BMI greater than 40 or BMI less than 35 with co-morbidities), Renal failure, and Eating Disorders. *Prior authorization is required for anything over 12 visits.
c. Outpatient nutritional counseling and psychosocial counseling are limited to 25 visits per therapy, per Member per Calendar Year.
d. For coverage limitations, consult Your SOB and Prior Authorization list.

13. Emergency Care Services

Under the Affordable Care Act (ACA), PPHIC is not permitted to charge higher copayments or co-insurance for Out-of-Network emergency room services, or require approval before seeking emergency room services from a provider or hospital outside the provider network. Grandfathered health insurance policies are not required to follow these rules.

The PPHIC Emergency Services are provided as follows:

a. Without regard to whether the provider of the services is in-network;
b. If the services are out-of-network, without administrative requirements or coverage limitations that are more restrictive than those imposed on in-network services; and
c. Without regard to any other term or condition of the coverage, other than (1) the exclusion of or coordination of benefits; (2) an affiliation or waiting period permitted under ERISA, the PHSA, or the Internal Revenue Code, or (3) applicable cost sharing.
d. If a member receives services from an out of network provider, the provider is prohibited from collecting from a person covered by a policy of health insurance an amount for medically necessary services that exceeds the copayment, coinsurance, or deductible required by that policy.
e. As used in this section, “Medically Necessary Emergency Services” healthcare services that are provided to a Member by an In-Network Practitioner/Provider of healthcare after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that a prudent person would believe the absence of immediate medical attention could result in:
    i. Serious jeopardy to the health of a Member;
    ii. Serious jeopardy to the health of an unborn child;
    iii. Serious impairment of a bodily function; or
    iv. Serious dysfunction of any bodily organ or part.

Examples include, but are not limited to, heart attacks, severe chest pains, burns and loss of consciousness. Criteria is based on signs and symptoms at the time of treatment, and verified by the treating physician.

Emergency Care Services does not include instances when You are seen in a contracted emergency room for a condition that was not Medically Necessary and that PPHIC determines did not require Emergency Services.

14. Genetic Testing

a. Coverage is provided for Genetic Counseling/Testing as prescribed and must be coordinated by an In-Network Practitioner/Provider.
b. Genetic testing may only be done after consultation with an appropriately certified Genetic Counselor.
c. Genetic testing will be covered in connection with pregnancy management in the following circumstances:
    i. Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;
    ii. Parents of a child with mental retardation, autism, down syndrome, trisomy conditions, or fragile X syndrome;
    iii. Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) 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;
    iv. Parents affected with an autosomal dominant disorder, contemplating pregnancy;
    v. Mother is a known or presumed carrier of an X-linked recessive disorder.
d. Genetic testing unrelated to pregnancy is covered in conjunction with covered genetic tests and in accordance with the guidelines of the American College of Medical Genetics (ACMG)
e. For coverage limitations, please contact your SOB and Prior Authorization list.

15. Health and Wellness Services

a. Online Health Risk Assessment; provides Members with a comprehensive health assessment, and personalized educational resources.

16. Hemophilia Services

Coverage is provided for Medically Necessary Covered Services for the non-experimental treatment of hemophilia including, but not limited to, blood products/factor.

17. Home Health Services

a. Medically Necessary care in the home requiring skilled services by healthcare professionals include but are not limited to, nurses, physical therapists, respiratory therapists, speech therapists, occupational therapists and others, are a Covered Service for homebound patients. Home Health Services may require Prior Authorization by PPHIC.
b. For coverage limitations, consult your SOB and Prior Authorization list.

18. Hospice Care

A Member is considered terminally ill if an In-Network Practitioner/Provider has certified the Member as having a life expectancy of six months or less.

a. Coverage is provided for drugs and medical supplies provided by the Hospital or Hospice.
b. Bereavement Services counseling limited to a maximum benefit of five (5) therapy sessions per year. Treatment must be completed within six (6) months of the date of death of the terminally ill Member.
c. Respite Services for a Hospice patient's family, including care for the patient which provides a respite from the stresses and responsibilities that result from the daily care of the patient and bereavement services provided to the family after the death of the patient. Inpatient Respite Services limited to a maximum benefit of ten (10) days per calendar year.
d. For coverage limitations, consult your SOB and Prior Authorization list.

19. Hospital Services

a. **Inpatient Services:** Coverage is provided for the following Medically Necessary Covered Services and may require Prior Authorization by PPHIC. It is the Member's responsibility to notify Prominence Preferred Health Insurance Company of an inpatient hospital admission within 48 hours or the next business day; failure to notify Prominence Preferred Health Insurance Company will result in a financial penalty.
   i. Semi-private room and board, with no limit to number of days except as described in Your Summary of Benefits for Mental Health Inpatient Services.
   ii. Inpatient In-Network Practitioner/Provider Services.
   iii. Laboratory, x-ray, and other diagnostic services.
   iv. Drugs, medications, biologics and their administration.
   v. Use of operating and delivery rooms and related facilities.
   vi. Anesthesia and oxygen services.
   vii. Physical therapy and other rehabilitation services required as part of a Medically Necessary Hospital stay. Coverage is limited to Covered Services that are anticipated to result in significant clinical improvement within a reasonable period of time.
   viii. Radiation therapy, chemotherapy, infusion therapy and dialysis.
   ix. Blood and blood plasma products and their administration.
   x. Cardiac Rehabilitation Program Phase I.

b. **Outpatient, Ambulatory and Surgical Services:** Coverage is provided for the following Medically Necessary Covered Services.
   i. Radiation therapy, chemotherapy, infusion therapy and dialysis.
   ii. Short Term Rehabilitative Services are limited to treatment of conditions which are subject to significant clinical improvement over a 3 month (90 day) period from the date inpatient or outpatient therapy commences for post-surgical conditions and over a 2 month (60 day) period from the date inpatient or outpatient therapy commences for all other conditions, and in the judgment of the Plan Medical Director is subject to significant clinical improvement.
   iii. Outpatient surgery and diagnostic procedures.
   iv. Cardiac Rehabilitation Program Phase II.
   v. When Your outpatient status changes to inpatient, You will be responsible for an inpatient Deductible/Coinsurance.
   vi. For coverage limitations, consult your SOB and Prior Authorization list.

c. **Inpatient Skilled Nursing/Acute Rehabilitation Facility:** Coverage is provided for Skilled Nursing/ Acute Rehabilitation Facility services when Medically Necessary.
   i. Coverage is provided for care in a Skilled Nursing/Acute Rehabilitation Facility, provided these services are of a temporary nature and lead to rehabilitation and increased ability to function.
   ii. If You remain in a Skilled Nursing/Acute Rehabilitation Facility after discharge by an In-Network Practitioner/Provider, or after the maximum benefit period is reached, You will be financially responsible for all associated costs for the services.

d. For coverage limitations, consult your SOB and Prior Authorization list.

20. Kidney Dialysis Services

a. Coverage is provided for Medically Necessary kidney dialysis services and related therapeutic services and supplies, e.g., Epogen, to the extent not covered by the Medicare Program. These services must be coordinated by an In-Network Practitioner/Provider.
b. For coverage limitations, consult your SOB and Prior Authorization list.

21. Laboratory and Pathology Services

a. Coverage is provided for Medically Necessary prescribed services when required to diagnose or monitor a symptom, disease or condition. Services include, but are not limited to, laboratory and pathology services when prescribed and coordinated by an In-Network Practitioner/Provider.
b. For coverage limitations, consult your SOB and Prior Authorization list.

22. Maternity and Newborn Care

a. Maternity Care: Coverage is provided for Medically Necessary maternity care services for any hospital length of stay in connection with childbirth for a mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. Services include:
    i. Prenatal and Postpartum care including any and all complications of pregnancy.
    ii. Amniocentesis when performed in the last trimester for the purpose of determining fetal lung maturity, in the first 16 weeks for genetic testing or the need for fetal therapy.
    iii. Use of Hospital delivery room and related facilities may require Prior Authorization by PPHIC.
    iv. Use of Newborn nursery and related facilities.
    v. For coverage limitations, consult your SOB and Prior Authorization list.

23. Mental Health And Substance Abuse Benefit

PPHIC will provide mental health and substance abuse benefits to covered Members in compliance with the Mental Health Parity and Addiction Equity Act, Benefits provided are subject to all conditions, limitations, and exclusions listed in the COC document. Refer to the SOB document for the corresponding copayment amount for each covered service. Payment made for treatment for mental health or substance abuse will be made directly to the provider of health care.

a. Alcohol and Drug Addiction or Abuse Services Benefit Description
    i. Withdrawal Treatment: Coverage is provided for Medically Necessary Covered Services relating to the physiological effects of alcohol or drugs on either an inpatient or outpatient basis when coordinated by an In-Network Practitioner/Provider.
    ii. Inpatient/Residential Rehabilitation: Coverage is provided when there has been a history of multiple outpatient treatment failures or when outpatient treatment is not feasible.
    iii. Detoxification: Coverage is provided for treatment for withdrawal from the physiological effects of alcohol and drug abuse. Inpatient detoxification is considered appropriate treatment only for life-threatening withdrawal syndromes associated with drug and alcohol dependence.
    iv. Outpatient Rehabilitation/Day Treatment: Coverage is provided for Medically Necessary Covered Services for the abuse of alcohol or drugs when coordinated by an In-Network Practitioner/ Provider. Depending on the duration of the Outpatient Rehabilitation program, this benefit may require Member to pay the Hospital Outpatient share of cost which is found on the Member's SOB.
    v. Counseling Services / Outpatient Office Visits: Coverage for individual or group counseling is provided for covered Members for Medically Necessary covered outpatient counseling services related to the abuse of alcohol or drugs.
b. Mental Health Disorders Benefit Description
    i. General Mental Health: Coverage is provided for outpatient general mental health, when coordinated by In-Network Practitioners/Providers. Services are limited to evaluation, crisis intervention and short-term psychotherapy which will lead to significant clinical improvement and achieve treatment goals. Examples of Covered Services include phobias, bereavement, marriage and family therapy. Services include Outpatient Office Visits with a mental health professional.
        1. Severe Mental Illness: Coverage is provided for Medically Necessary severe mental illness services when coordinated by In-Network Practitioners/Providers. Treatment is limited to the following conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders and/or obsessive compulsive disorder.
        2. Severe Mental Illness benefits include Inpatient treatment, Outpatient Office Visits and Day Treatment Programs.
        3. Depending on the duration of the Day Treatment Program, this benefit may require Member to pay the Hospital Outpatient share of cost which is found on the Member's SOB.
c. For coverage limitations, please consult Your SOB.

24. Morbid Obesity

a. Bariatric Restrictive Services are covered when all of the following have been determined and are limited to one procedure per Member per lifetime:
   i. The Member must have either:
      1. BMI ≥ 40 kg/m2 without co-morbidities;
      2. BMI ≥ 35 kg/m2 and a high-risk obesity-related condition or a combination of three other obesity-related diseases or cardiovascular risk factors (documented evidence of risk factors required)
         001. High risk diseases are Chronic coronary disease, atherosclerosis, Type 2 diabetes or sleep apnea.
         002**.** Other obesity-associated diseases include osteoarthritis, gallstones, stress incontinence and gynecologic abnormalities.
         003**.** Limited to 18 to 60 years of age.
         004. Cardiovascular risk factors included but are not limited to, history of cigarette smoking, hypertension, high LDL-cholesterol serum levels, low HDL-cholesterol serum levels, impaired fasting glucose, family history of premature CHD.
   ii. There is adequate documentation that the Member has failed less invasive methods of weight loss and is at high risk for obesity-associated morbidity or mortality. Less invasive therapies include low-calorie dieting, increased physical activity, behavioral therapy and pharmacotherapy, where appropriate.
      01. The less invasive therapy must have been in place for more than a continuous six month period.
      02. Failure of less invasive methods is determined by the Plan Medical Director and his/her designee.
   iii. Member has been obese for at least five years;
   iv. If Member is diabetic, disease is controlled;
   v. Member must have the capacity to be compliant with post-surgical treatment or follow-up requirements, which may include a psychiatric or behavioral evaluation;
   vi. Procedure must be performed at an In-Network Facility unless pre-approved by PPHIC to be performed at an Out-of-Network Facility/Provider.
   vii. Member must be tobacco free for (8) eight weeks prior to surgery.
   viii. For coverage limitations, consult your SOB and Prior Authorization list.

25. Nutritional Supplements, Enteral Therapy and Parenteral Nutrition

a. Coverage is provided for enteral formulas for use at home when prescribed or ordered by an In-Network Practitioner/Provider as medically necessary or the treatment of "inherited metabolic diseases" characterized by deficient metabolism or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and
b. Special food products which are prescribed or ordered by an In-Network Practitioner/Provider as Medically Necessary for treatment mandated by Nevada State Law (NRS 695C.1723). At least $2,500 per year for special food products that are prescribed or ordered by a physician as medically necessary for treatment.
c. As used in this section:
   i. "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.
   ii. "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.
d. If a Member does not have an inherited metabolic disease, but whose sole source of alimentation (nutritional intake) is by enteral formula, then they too are entitled to coverage.

e. Total Parenteral Nutrition (TPN) received in the home is a covered benefit for 21 days when it is determined to be medically necessary. Continuation of TPN may be considered if medically appropriate upon review every 21 days.
f. For coverage limitations, consult your SOB and Prior Authorization list.

26. Organ Transplant Services

Coverage is provided for Medically Necessary Covered Services for the non-experimental organ transplants listed below, for the treatment of non-occupational disease or injury. All transplant-related services may require Prior Authorization from the PPHIC Medical Director.

a. Transplants to a Member are limited to heart, kidney, cornea, liver, lung, tendons, sclera, and allogenic and autologous bone marrow only.
b. Coverage is provided for the necessary Hospital, surgical, laboratory, and x-ray expenses incurred by a donor for an Authorized transplant to a Member, unless the donor has coverage for such expenses. Donor care is limited to 60 days following the transplant procedure. Donor care following the transplant procedure is limited to services and supplies related to the transplant only.
c. There is no coverage for a Member acting as a transplant donor to a non-PPHIC Member.
d. Transplants utilizing any animal organs are not a Covered Service.
e. Procedures must be performed at a PPHIC Transplant network facility.
f. For coverage limitations, consult your SOB and Prior Authorization list.

Combined expenses incurred for any and all human body organ transplant services, including follow-up care, Home Health care, immunosuppressive medications and donor expenses for non- experimental human-to-human procedures.

Immunosuppressive post-transplant medications may be covered under the medical plan or pharmacy benefit depending on the prescription drug dispensed. Immunosuppressive post-transplant self-injectables are covered with a 20% Member responsibility (coinsurance).

27. Plastic and Reconstructive Surgery

Medically Necessary Covered Services may require a Prior Authorization by PPHIC:

a. Reconstructive surgery is incidental to or follows surgery resulting from acute trauma, infection, or other diseases of the involved body part while insured with PPHIC.
b. A Congenital disease or anomaly has caused a functional defect, but only when the surgery is reasonably expected to correct the condition.
c. Reconstructive surgery following a mastectomy for breast cancer on one or both breasts to reestablish symmetry. This benefit includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.
d. For coverage limitations, consult your SOB and Prior Authorization list.

28. Prescription Drug Benefit

A Member is eligible for prescription drug benefits only when the prescription is written by an In-Network Practitioner and filled at a PPHIC Plan Pharmacy except in connection with covered emergency services while outside of the PPHIC service area. Each prescription refill is considered a separate prescription, and a separate copayment will be charged for each. Outpatient prescription drugs include covered drugs which are approved by the U.S. Food and Drug Administration (FDA).

i. Plan Pharmacy: a pharmacy contracted with PPHIC to dispense Prescription Drugs to Members for benefits under the prescription drug benefit. The Plan Pharmacy list is available from PPHIC.
ii. Out-of-Network Pharmacy: a pharmacy not contracted with PPHIC as a Plan Pharmacy.

a. Prescription Drug (or "Prescription"): drugs or medications which, according to federal law, can only be obtained legally with a written prescription from a licensed practitioner; it's required to bear a label which says, "Caution: Federal Law Prohibits Dispensing without a Prescription," or is restricted to prescription dispensing by state law. The drug must have received final approval from the (FDA) for the indicated use.
b. Formulary: Prescription drug coverage requires Members to use the PPHIC Formulary. This list of medications is created and maintained by the PPHIC Pharmacy and Therapeutics Committee, based upon current medical standards of practice. Some medications on the Formulary may require prior authorization and/or have a limited benefit. Approved U.S. Food and Drug Administration (FDA)

female oral contraceptive generic drugs are listed in the PDL. If you wish to receive a copy of the PPHIC Formulary, contact the Customer Service Department at 775-770-9312 or 800-863-7515.

i. Pharmacy and Therapeutics Committee: the Pharmacy and Therapeutics Committee, at least on an annual basis, reviews new and existing categories of drugs, using the recommendations of medical and surgical specialists, pharmacists and other health care professionals in their decision making process. The evaluation of drugs for inclusion on the Formulary is based on information from reference medical and pharmacy journals, and standards of practice. Preferred drug evaluations are based on several factors:
    - FDA-approved indications
    - Efficacy
    - Adverse effect profile
    - Patient monitoring requirements
    - Impact on total healthcare costs
    - Comparison to other preferred agents

c. Covered Contraceptive Pharmaceuticals: Oral contraceptive drugs and other FDA approved medications and devices prescribed for birth control. FDA approved female Oral Contraceptive Generic Drugs and select preventive medications listed on the Formulary require no Member share of cost when prescribed by your Primary Care Practitioner or other PPHIC In-Network Practitioner and obtained from a PPHIC Plan Pharmacy.

d. Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, require payment of the prescribed copayment as listed in the PPHIC Summary of Benefits document. Member must pay the copayment to the Plan Pharmacy at the time the Prescription is filled, for each prescription or refill dispensed, up to a 30-day supply.
    i. Generic Drug: a prescription drug chemically equivalent to a Name Brand Drug whose patent has expired. The drug's generic/brand status may change without notice.
    ii. Preferred Brand Drug: a prescription drug patented and given a brand or trade name by the drug manufacturer.
    iii. Non-Preferred Brand Drug: A Name Brand Drug which often has a Generic equivalent, and which is listed on the PDL.

e. The Oral Chemotherapy Parity Law applies to health policies issued or renewed on or after January 1, 2015. This law requires health policies that provide coverage for the treatment of cancer through chemotherapy must not require a co-payment, coinsurance or deductible of more than $100 per prescription for orally administered anticancer treatment. The limitation on the amount of the deductible that may be required does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

f. Coverage for use of certain drugs for treatment of cancer
This policy of health insurance provides coverage for drugs approved by the Food and Drug Administration for use in the treatment of cancer. Coverage provided includes medical services necessary to administer the drug to the employee or member of the insured group. Coverage does not include experimental drugs used for the treatment of cancer if that drug has not been approved by the Food and Drug Administration; or use of a drug that is contraindicated by the Food and Drug Administration.

g. The prescription drug benefit provides for early refills of topical ophthalmic products due to inadvertent wastage in compliance with Nevada law.

h. Specialty Pharmacy: Some Specialty Drugs require the Member to obtain the drug through the PPHIC Specialty Drug provider. Contact Customer Service for more information.

i. Maintenance Drugs: Drugs available in a 90-day supply at retail pharmacies or through mail order.. Specialty Drugs are not considered Maintenance drugs; they cannot be purchased with a 90-day supply.

j. Diabetic Supplies: Mail order diabetic blood test strips, urine test strips, syringes and lancets require two copayments for each 300 quantity of Preferred Brand supply or three copayments for each 300 quantity of Non-Preferred diabetic supply. For additional information about Diabetic Supplies, please see the Diabetic Services and Supplies section of this document.
k. Dispense as Written Provision: Prescription Drugs will always be dispensed as ordered by your physician. You may request, or your physician may order, the brand name drug. However, if a Generic drug is available, you will be responsible for the cost difference between the Generic and brand name drug, in addition to your Generic copayment.
l. Step Therapy: The process for determining the best medication to help treat an ongoing condition such as arthritis, asthma, or high blood pressure. One drug must be dispensed and tried before dispensing the next drug for the condition – this is known as "steps" of therapy. Step Therapy requires use of one of more medications before a similar, more expensive, Brand Name drug is dispensed. This means that Step Two drugs will not be covered until Step One prescription drugs are tried first, unless your physician contacts PPHIC to obtain a Prior Authorization list. Drugs which require step Therapy are listed in the Preferred Drug List (PDL).
m. The prescription drug benefit includes coverage for early refills of topical ophthalmic products due to inadvertent wastage.
n. The prescription drug benefit includes coverage for synchronized medication packs dispensed by a pharmacy.
o. The prescription drug benefit includes coverage for a previously approved drug for a medical condition of an insured and the insured's provider of health care determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured; and Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.
p. Prescription Drug Benefit Exclusions
    i. Cosmetic and Aging of the Skin Products: cosmetic products, health and beauty aids including all products used to retard or reverse the effects of aging of the skin, whether prescription or non-prescription, and any drugs/products for the treatment of hair loss.
    ii. Dietary Aids and Appetite Suppressants: dietary or nutritional products, including prescription or non-prescription vitamins (except those prescribed pre-natal vitamins listed on the PPHIC Preferred Drug List), appetite suppressants, and diet pills used for weight reduction, except as otherwise permitted in the Certificate of Coverage and Summary of Benefits documents.
    iii. Experimental or Investigational: drugs labeled "Caution: Limited by Federal Law to Investigational Use," as well as drugs either not approved by the Federal Drug Administration as "safe and effective" or, if so approved, which are intended to treat a condition for which the U.S. Food and Drug Administration (FDA) has not approved its use, whether used on an inpatient or outpatient basis, except as otherwise permitted under Federal or State law.
    iv. Fertility Drugs: Drugs/Products used for the treatment of impotence or infertility.
    v. Smoking Cessation: smoking cessation drugs and/or aids whether Prescription or Non-Prescription (unless used in conjunction with the PPHIC smoking cessation program).
    vi. Nail Fungal Medications and/or Preparations.
    vii. Non-Covered Drugs: any prescription drug prescribed in connection with a Non-Covered Service. This includes any drug not listed on the Formulary.
    viii. Non-Approved Drugs: drugs determined by the PPHIC Pharmacy and Therapeutics Committee as ineffective, duplicative, or having preferred formulary alternatives.
    ix. Over-the-Counter Drugs: over-the-counter drugs and other items which do not require a written prescription (even if ordered by a PPHIC In-Network Practitioner).

29. Preventive Services

a. Periodic health assessments, i.e., annual physicals for adults, as recommended by Your PCP or the U.S. Preventive Services Task Force based upon Your age, gender and medical history.

b. Periodic Gynecological examination and cytological screening for females as recommended by Your PCP or as per recommendations from the Health Resources and Services Administration at http://www.hrsa.gov/womensguidelines/
c. Baseline and periodic mammography for females as recommended by Your PCP or as per recommendations from the U.S. Preventive Services Task Force. Coverage is also provided for an annual cytologic screening test for women age 18 years of age and older, a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.
d. Prostate screening as recommended by Your PCP or as per recommendations from the U.S. Preventive Services Task Force.
e. Well child visits and annual physicals as recommended by your PCP or as per recommendations from the U.S. Preventive Services Task Force.
f. Vision and hearing screening examinations for ages 19 and under to determine the need for vision and hearing correction as recommended by your PCP or as per recommendations from the U.S. Preventive Services Task Force Screening does not include determination of refractive state. Frames and lenses for the care of Strabismus (cross-eyed) are limited to one exam per calendar year.
g. Childhood and adolescent immunizations, vaccinations and state mandated immunizations as per recommended by the Advisory Committee on Immunization Practices are covered.
h. Adult immunizations and vaccinations as per recommendations from the Advisory Committee on Immunization Practices are covered.
i. Colorectal cancer screening in accordance with the guidelines published by recommendations from the U.S. Preventive Services Task Force.
j. Vaccines for human papillomavirus at such ages as per recommendations from the Advisory Committee on Immunization Practices.
k. Women's Preventive Services
    i. (FDA) approved contraceptive products.
    ii. Domestic and interpersonal violence screening and counseling.
    iii. Well-woman visits.
    iv. Gestational diabetes screening.
    v. Human Papillomavirus (HPV) DNA testing, for women 30 or older.
    vi. Sexually transmitted infections (STI) counseling.
    vii. HIV Screening and Counseling
    viii. Breastfeeding support, supplies, and counseling.
    ix. For coverage limitations, consult your SOB and Prior Authorization list.
    x. For more information visit http://www.hrsa.gov/womensguidelines/

30. Professional Services

a. In-Network Practitioner/Provider Office Visits: Medically Necessary Covered Services are provided for the diagnosis and treatment of illness or injury when provided in the medical office of an In- Network Practitioner/Provider.
b. In-Network Practitioner/Provider Hospital Visits: Medically Necessary Covered Services for diagnosis, treatment and consultation are provided for inpatient and outpatient Prior Authorized Hospital Services.
c. In-Network Practitioner/Provider Home Visits: Medically Necessary care in the home requiring skilled services by healthcare professionals including, but not limited to, nurses, physical therapists, respiratory therapists, speech therapists and occupational therapists are a Covered Service for homebound patients.

31. Prosthetic and Orthotic Devices

a. Prosthetic devices that aid body functioning or which replace a limb or body part after accidental or surgical loss to correct a defect of body form and function as defined by Medicare DME guidelines are a covered service. Benefits are provided only for the basic Prosthetic.
Prosthetic devices are limited to artificial limbs and eyes and orthopedic braces and supports which are custom-made for You. Specifically not covered are: special shoes, insoles, corsets, trusses and all other such devices. The maximum benefit may be applied to computer-aided Prosthetic devices.

b. Orthotics and artificial aids, such as cardiac pacemakers and artificial heart valves, are a Covered Service when Medically Necessary.
c. Foot orthotics are limited to one pair per Member per Calendar Year.
d. The Prosthetic or Orthotic devices are defined by the Medicare DME guidelines.
e. Benefits are provided for the initial prescription lenses, eyeglasses or contact lenses, following an operation for cataracts and post-corneal transplants. Eyeglasses and contact lenses are limited to one basic pair per calendar year.
f. Prescription lenses, eye glasses or contact lenses for treatment of keratoconus are limited to one basic pair per calendar year.
g. For coverage limitations, consult your SOB and Prior Authorization list.

32. Radiology and Diagnostic Services

a. Coverage is provided for Medically Necessary prescribed radiological and diagnostic services when required to diagnose or monitor a symptom, disease or condition. Services include, but are not limited to, routine radiology and ultrasound and, diagnostic testing and complex diagnostic testing when coordinated by an In-Network Practitioner/ Provider.
b. Coverage is provided for Diagnostic Colonoscopy and Sigmoidoscopy as Medically Necessary.
c. For coverage limitations, consult your SOB and Prior Authorization list.

33. Sex Re-Assignment (Gender Reassessment

When Medically Necessary the following Covered Services are provided when coordinated by an In- Network Practitioner/Provider, and may require Prior Authorization by Prominence HealthFirst.

a. Requirements for mastectomy for female-to-male patients:
    i. Single letter of referral from a qualified mental health professional *and*
    ii. Persistent, well-documented gender dysphoria (see Appendix); *and*
    iii. Capacity to make a fully informed decision and to consent for treatment; *and*
    iv. Age of majority (18 years of age or older); *and*
    v. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note: a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

b. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):
    i. Two referral letters from qualified mental health professionals, one in a purely evaluative role; *and*
    ii. Persistent, well-documented gender dysphoria; *and*
    iii. Capacity to make a fully informed decision and to consent for treatment; *and*
    iv. Age of majority (18 years or older); *and*
    v. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
    vi. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)
c. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female) are as follows:
    i. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
    ii. Persistent, well-documented gender dysphoria (see Appendix); *and*
    iii. Capacity to make a fully informed decision and to consent for treatment; *and*
    iv. Age of majority (age 18 years and older); *and*
    v. If significant medical or mental health concerns are present, they must be reasonably well

controlled; *and*

vi. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); *and*

vii. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans-identified persons who have not undergone a mastectomy;

Prostate cancer screening may be medically necessary for male to female trans-identified persons who have retained their prostate.

34. Spinal Manipulation

a. Spinal manipulation covers treatment of acute back, shoulder and neck conditions when they interfere with normal functions.
b. Spinal manipulation for Chronic/Supportive conditions, maintenance, and/or preventive therapy is not a Covered Service (see definition for Chronic/Supportive).
c. If no improvement is documented within the initial two weeks, additional spinal manipulation treatment is not Medically Necessary and is not covered unless the spinal manipulation treatment is modified.
d. If no improvement is documented within 30 days despite modification of spinal manipulation treatment, continued spinal manipulation treatment is not considered Medically Necessary and is not covered. Once the maximum therapeutic benefit has been achieved, continuing spinal manipulation is not considered Medically Necessary and thus is not covered.
e. Coverage for pediatric patients, ages 0-11, is only authorized for spinal manipulation, and only when Medically Necessary.
f. For coverage limitations, consult your SOB and Prior Authorization list.

35. Telehealth

To the extent that a contracted provider is able to provide Telemedicine services, Prominence Health Plan will cover services to an insured through Telemedicine to the same extent and in the same amount as though provided in person. Prominence Health Plan will not require a Prior Authorization for use of Telemedicine services if that service does not require a Prior Authorization when it is provided in person.

36. Therapies (Physical, Occupational, Speech and Autism)

a. Speech, physical, developmental and occupational therapy are provided on a Short Term outpatient basis and must be coordinated by an In-Network Practitioner/Provider. Outpatient Short Term Rehabilitation Services are limited to treatment of conditions the Plan Medical Director determines to result in significant clinical improvement.
b. Habilitative Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
c. Rehabilitative Services: Physical, speech, occupational, cardiac and pulmonary/respiratory therapy
d. Autism Spectrum Disorder: A condition that meets the diagnostic criteria for Autism Spectrum Disorder published in the current edition of the "Diagnostic and Statistical Manual of Mental Disorders" published by the American Psychiatric Association or the edition of the Manual that was in effect at the time the condition was diagnosed or determined.
    - 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 that is:

- Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
- Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist, or behavior analyst. This also includes an Autism Behavior Interventionist who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of a licensed psychologist, licensed behavior analyst, or a licensed assistant behavior analyst.
- The maximum Benefit is up to 750 hours per member per calendar year.

e. For coverage limitations, consult your SOB and Prior Authorization list.

37. Urgent Care Services

a. Urgent/Ambulatory Care Services - All benefits included in this COC are designed to be available for Medically Necessary Covered Services, which are provided in the most appropriate care setting. "Urgent/Ambulatory Care Services" are defined as care for an injury, illness or another type of condition that should be treated within 24 hours. Routine or follow-up care is not considered urgent care and must be provided by Your Primary Care Physician. When You are seen in an Urgent/Ambulatory Care facility for a condition not Medically Necessary and that Prominence HealthFirst determines did not require Urgent/Ambulatory services, or fail to follow the proper procedures as defined above, You will be held financially responsible for all charges related to this visit. In addition, PPHIC will not pay benefits for services or supplies received outside of the Service Area if, in the opinion of the Plan Medical Director, the need for such services or supplies could have been foreseen before leaving the Service Area. In addition, PPHIC will not pay benefits for services or supplies received at an Out-of-Network Practitioner/Provider within the Service Area.
b. In-Area Urgent/Ambulatory Care Services - All Medically Necessary Urgent/Ambulatory Care services must be obtained through a contracted Urgent/Ambulatory Care In-Network Practitioner/Provider. Continuing or follow-up care for an Urgent/Ambulatory Care service must be provided by Your Primary Care Physician. Any continued or follow-up care a Member receives at an Urgent/Ambulatory Care facility is not a Covered Service.
c. Out-of-Area Urgent/Ambulatory Care Services - Out-of-Area Urgent/Ambulatory Care services are covered for Medically Necessary Covered Services.
d. For coverage limitations, please consult your Summary of Benefits and Prior Authorization list.

38. Women's Health and Cancer Rights Act (WHCRA)

Benefits are provided for breast reconstructive surgery required as a result of a mastectomy. If reconstructive surgery begins within three years after mastectomy, coverage will be extended to the Member for all eligible charges for such reconstructive surgery as would have been provided at the time of the mastectomy. If the surgery begins more than three years after the mastectomy, the benefits provided are subject to all the terms and exclusions contained in the COC in effect at the time of the reconstructive surgery. Under this COC, Plan benefits will be provided to a Member who is receiving benefits for Medically Necessary mastectomy and who elects breast reconstruction after the for:

a. Reconstruction of the breast on which a mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prosthesis benefits are provided for portable breast prosthesis required as a result of mastectomy. This benefit is limited to a maximum of 2 per Calendar Year. Prosthetic bras are limited to two per Member per calendar year.
d. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

Part VII. Exclusions, Limitations and Non-Covered Services

Any service or item not considered Medically Necessary by an In-Network Practitioner/Provider. The final determination of Medical Necessity is the judgment of the PPHIC Medical Director. In addition to the Exclusions and Limitations described in Part VII, this COC does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

1. **Bariatric services** - Any reconstructive and/or cosmetic procedure following bariatric restrictive surgery and/or excessive weight loss to remove excess skin on any part of the body. Procedures including but not limited to, lifts, tucks, abdominoplasty, and body contouring, regardless of medical necessity.

   Surgical or invasive treatment, or reversal thereof, for reduction of weight regardless of associated medical or psychological conditions except as otherwise permitted in the Certificate of Coverage.

2. **Chelation treatment** - Chelation Therapy, except for recognized or standard medical care to treat heavy metal poisoning.

3. **Complication of non-covered service** - Complications resulting from excluded a) cosmetic treatment or b) medical/surgical procedures.

4. **Convenience items and services** - Personal comfort, convenience and duplicate items, services, supplies or equipment, including exercise equipment which is primarily for the Member's education, training or development of skills needed to cope with an injury, sickness or condition. Supplies and consumables including, but not limited to, dressing, any equipment to condition the air, appliances, ambulatory apparatus, heating pads, personal care or beautification items, deluxe equipment, wheel chair lifts, four-channel muscle stimulators and any other primarily non-medical equipment. Special equipment and devices used for sports.

5. **Compression stockings** - Compression stockings with a pressure gradient of less than 18mm Hg including but not limited to, elastic stockings, surgical leggings, anti-embolism stockings (Ted Hose) or pressure leotards.

6. **Cosmetic services** - Cosmetic surgery or treatment defined as any plastic or reconstructive surgery or procedure done primarily to improve the appearance of any portion of the body in the absence of specific functional limitations from which no substantial clinical improvement in physiologic function could be reasonably expected. Cosmetic Exclusions include, but are not limited to, the following:
   i. Abdominoplasty, regardless of medical necessity;
   ii. Surgery for sagging or extra skin; to include thigh, leg, hip, buttock, arm, forearm and hand, regardless of medical necessity;
   iii. Face lifts, brow lifts and rhinoplasty, regardless of medical necessity;
   iv. Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedure to alter Refraction;
   v. Any augmentation or reduction procedures or correction of facial or breast asymmetry. Breast augmentation, lifts or reductions which are not associated with cancer of the breast, regardless of medical necessity; or any removal of breast implants or breast reconstruction which is not associated with breast cancer. Breast reductions and removal of ruptured breast implants (not replacements unless related to a prior mastectomy) may be covered when prior authorized and medically necessary.
   vi. Hair removal or treatment of baldness;

vii. Scar revision therapy and laser services for scars;
viii. Any implant, appliances or devices used to improve the appearance and/or function of a portion of the body, regardless of medical necessity;
ix. Earring injuries and/or earlobe repairs;
x. All body piercings;
xi. Treatment for melasma, hyperpigmentation, hypopigmentation, port wine stain, birth marks, chemical peels and laser treatment of acne, surgical treatment of rosacea, telangiectasia and spider veins, benign lesions and skin disorders, including lipomas but not limited to, hemangiomas and seborrheic keratosis, regardless of medical necessity.
xii. Psychological factors, e.g., for self-image, difficult social or peer relations, are not relevant and constitute a physical bodily function. Examples of Non-Covered Services include, but are not limited to, tattoo removal, liposuction and wigs.

7. **Court ordered services** - Court ordered treatments including, but not limited to, long-term mental health, chemical dependency and psychiatric treatment. Pretrial or court testimony and/or the preparation of court-related reports are also not covered under this Plan, as well as, any care or service while incarcerated.

8. **Dental** - Dental care including but not limited to, treatment of the teeth, extraction of teeth (including wisdom teeth), dental surgery and/or oral surgery, treatment of dental abscesses, treatment of gingival tissues (other than tumors), dental examinations, dental implants, bridges, dental prescriptions, orthodontia and any other dental products or services.
   i. Treatment or replacement of any tooth or any supporting tooth structure, alveolar process or disease of the periodontal or gingival tissue;
   ii. Surgery or splinting to adjust dental occlusion;
   iii. Maxillary or mandibular surgery;
   iv. Any irreversible procedure including, but not limited to, orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures.
   v. Hospital call

9. **Dermatology** – Removal of benign skin lesions is considered cosmetic except as otherwise specified in this document.

10. **Developmental and educational testing or treatment** - Testing and treatment for educational or behavioral disorders, non-medical ancillary services such as work hardening treatment, vocational rehabilitation, cognitive therapy, employment counseling return-to-work evaluations. Services, treatment and evaluation for Developmental Delays, speech therapy which is educational in nature and any other education services which are provided through a school district, special school, learning center, treatment and services for learning disabilities and Developmental Delays.

11. **Double coverage -** Cost of health services resulting from accidental bodily injuries to the extent such services are payable under any insurance or other such liability coverage, by whatever terminology used, including such benefits mandated by law, excluding any automobile insurance policy.

12. **Duplicate Items -** Duplicate items, services, supplies or equipment to be used, outside the home or for work or travel.

13. **Examinations/Immunizations -** Physical examinations or immunizations when required for employment, insurance, licensing, marriage, sports, education or travel and physical or work hardening capacity examinations.

14. **Experimental/investigational -** Any services that in PPHIC's sole discretion determines to be experimental or investigational medical, surgical or other procedures or treatments, including prescription medications – unless otherwise directed by State Federal regulations. A procedure or treatment considered experimental:
    i. If there is insignificant outcomes data available from controlled clinical trials and from to show that the procedure or treatment is safe and effective;
    ii. If the procedure or treatment has not been deemed consistent with accepted medical practice with standards established by the National Institutes of Health, the Food and Drug Administration, or the Medicare program;
    iii. If it is determined that the procedure or treatment is not generally accepted by the medical community within the State of Nevada;
    iv. When a nationally recognized medical society states in writing that the procedure or treatment is experimental;
    v. When the written protocols used by a facility studying the procedure or treatment state that it is experimental; and
    vi. When the treatment or service requires approval by any governmental authority prior to use and such approval has not been granted when the treatment or services is to be rendered.

15. **Family planning -** Services and procedures that have a direct and intended purpose for the induction of abortion. This Exclusion does not apply to medical complications arising out of any abortion or any treatment or procedure performed to save the life of a mother, even though it may result in the termination of the pregnancy. Any services, treatments or procedures to reverse voluntary elective sterilization.

16. **Foot care -** Routine foot care, including reduction of nails, calluses, and corns, except as otherwise permitted in this COC.

17. **Government operated facility -** Conditions that Federal, State or local law requires to be treated in a public facility. Care for military service-connected disabilities and conditions for which the Member is legally entitled to services and for which facilities are reasonably accessible to the Member.

18. **High risk injuries** - Injuries sustained as a result from professional competition in activities involving an unusually high degree of danger and risk of injury including, but not limited to, motorcycle racing, skiing, snowboarding, motor cross, bull riding, horseback riding and motor powered vehicle activities competing for money, prizes or trophies.

19. **Infertility treatment and diagnostic services -** Any infertility treatment or diagnostic service including Embryonic transfer, Gamete intra-fallopian transfer (GIFT), in vitro fertilization and sperm donation (including storage of) or any related services for treatment of infertility. Additional Exclusions include, but are not limited to, the following:
    - Advanced reproductive techniques such as embryo transplants, in vitro fertilization, GIFT and ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
    - Home pregnancy or ovulation tests;
    - Sonohysterography;
    - Monitoring of ovarian response to stimulants;
    - CT or MRI of sella turcica unless elevated prolactin level;
    - Sterilization reversal;
    - Laparoscopy;
    - Ovarian wedge resection;

- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants;
- Surgical lysis of adhesions;
- Surgical tube reconstruction.

20. **Illegal conduct -** Except as outlined services provided as a result of injuries sustained while in the act of committing a criminal offense, while being held by a law enforcement agency, pursued by law enforcement personnel or while incarcerated. Except in the case of conditions or injuries arising out of acts of domestic violence. This includes, but is not limited to, prisons and juvenile detention facilities.

    Medical and Hospital services provided as a result of injuries sustained while driving under the influence of controlled substances or alcohol, when convicted of a felony, as defined by current State law.

21. **Limitations -** In the event that due to circumstances not within the control of the PPHIC including, but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Plan's Practitioner/Provider's personnel or similar causes, the rendering of Professional or Hospital Services provided under this COC is delayed or rendered impractical, PPHIC shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Health Plan and In-Network Practitioner/Provider shall render Hospital and Professional Services provided under this COC insofar as practical, and according to their best judgment; but PPHIC and the Medical Plan Practitioner/Provider shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

22. **Long-term treatment -** Professional health services for people requiring assistance for an extended period of time due to a chronic condition or disability; custodial care, board and care, rest homes or homemaker services. "Custodial Care" is defined as care that serves to assist an individual in the activities of daily living; institutional care which is determined by the Plan Medical Director to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing) or rest cures are excluded from coverage.

23. **Maternity -** Amniocentesis. Collection and banking of cord blood Doulas and voluntary obstetrical home delivery including, but not limited to, all services and supplies.

24. **Medical services -** Services or benefits not provided by a PPHIC Plan In-Network Practitioner/Provider or not obtained in accordance with PPHIC's Prior Authorization requirements, except for Emergency care or as covered under the Coordination of Benefits provisions. Services that are not Medically Necessary or not required in accordance with accepted standards of medical practice.

    Services obtained outside of the Service Area for an absence exceeding 90 days.

    Payment for services which would normally be provided without charge, or services for which the Member would not otherwise be considered financially liable.

    Benefits or services rendered outside of the United States, except for Emergency Services.

25. **Never Events** - The National Quality Forum has identified certain events as occurrences that should never happen in a hospital and can be prevented. They termed them "serious reportable events" or never events. "Never events" are excluded from coverage. They include but are not limited to the following:

a. Air embolism, blood incompatibility, object left during surgery, catheter-associated urinary tract infections, pressure (decubitus) ulcers, vascular catheter-associated infection, surgical site infection, mediastinitis after coronary artery bypass graft (CABG) surgery, surgery performed on the wrong body part, surgery performed on the wrong patient, wrong surgical procedure performed, criminal events (e.g., sexual assault of a patient), falls and trauma, burns, electric shock, Legionnaires' disease, failed glycemic control (e.g., Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Hypoglycemic Coma), iatrogenic pneumothorax, delirium, ventilator- associated pneumonia, Staphylococcus aureus septicemia, clostridium difficile- associated disease (CDAD), and hospital-acquired injuries.

26. Non-covered providers of service - Membership costs for health clubs, weight loss clinics, sports medicine and similar programs.

Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, nursing home or any similar institution. Services provided by a person who lives with You in Your home or is a part of Your family. Private duty nursing and private Hospital rooms, Custodial Care, board and care, rest homes or homemaker services. "Custodial Care" is defined as care that serves to assist an individual in the activities of daily living. Institutional care which is determined by the Plan Medical Director to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

Supplies, medical care or treatment given by one of the following Members of the Member's immediate family:

i. The Member's spouse.
ii. A child, brother, sister, parent or grandparent of either the Member or the Member's spouse.
iii. Service or supplies rendered by someone who is related to an Insured Person by blood, e.g.,sibling, parent, grandparent, child, marriage (e.g., spouse or in-law) or adoption or is normally a Member of the Insured Person's household.
iv. Charges for treatment by an Out-of-Network Practitioner/Provider that are not within the scope of his/her license.

27. Non-covered therapies/services - Biofeedback, hypnosis, aromatherapy, aquatic therapy, massage therapy, rolfing therapy, sleep or snoring treatment, (except for central or obstructive apnea), behavior modification training or therapy, milieu therapy, sensitivity training, electronarcosis, reflexology, health spas, kinesiology, prolotherapy, auditory integration therapy, metabolic activation, CIIIT (Chronic Intermittent Intravenous Insulin Therapy) or PIVIT (Pulsat IV Insulin Therapy).

28. Not Listed Services or Supplies - Any services, care or supplies which are not specifically listed in the Evidence of Coverage as Services and Benefits will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage.

29. Not Medically Necessary/ Not Physicial Prescribed - Services for an illness, sickness, injury or condition which are not deemed Medically Necessary by the Plan, even when ordered by a Physician or other Covered Provider.

30. Over-the-Counter Supplies - Supplies that can be obtained without a Physician's prescription are not covered. Such supplies include but are not limited to ace bandages, band-aids, ankle supports, wrist supports, cotton balls, Neosporin, rubbing alcohol, latex gloves, Vaseline, toothettes, instant hot/cold packs, tourniquets, cleansing towelettes, thermometers, pant liners/disposable underpads.

31. **Pharmacy/drugs -** Costs related to the acquisition or use of medical marijuana. Prescribed drugs and medications including take-home drugs and medications incidental to a Hospital admission except when provided as part of an inpatient admission. Over-the-counter drugs, homeopathic, herbal medications and other substances not requiring a prescription even if ordered by a prescription from an In-Network Practitioner/Provider, drugs administered in an In-Network Practitioner/ Provider's office, if other than immunizations, allergy serum and chemotherapy drugs.

    Self-injectables, except for diabetic medications and supplies.

32. **Residential Treatment -** Residential Treatment, except that which is permitted and provided by an accredited facility.

33. **Saliva Testing -** Costs related to saliva testing.

34. **Sex Re-Assignment (Gender Reassessment)** The following procedures and services (not an all-inclusive list) that may be performed as a component of a gender reassignment are considered cosmetic and not a covered benefit.
    - Abdominoplasty
    - Blepharoplasty
    - Body contouring (liposuction of the waist)
    - Breast enlargement procedures such as augmentation mammoplasty and implants
    - Brow lift
    - Calf implants
    - Cheek/malar implants
    - Chin/nose implants
    - Collagen injections
    - Construction of a clitoral hood
    - Drugs for hair loss or growth
    - Face-lifting
    - Facial bone reduction
    - Feminization of torso
    - Hair removal
    - Forehead lift
    - Jaw reduction (jaw contouring)
    - Hair removal (e.g., electrolysis, laser hair removal)
    - Hair transplantation
    - Lip reduction
    - Liposuction
    - Lip enhancement
    - Masculinization of torso
    - Mastopexy
    - Neck tightening
    - Nipple reconstruction (as defined by the American Medical Association [AMA] Current Procedural Terminology [CPT] code 19350, cosmetic/not medically necessary for mastectomy for female to male gender reassignment. Performance of a mastectomy for gender reassignment does not involve a nipple reconstruction as defined by CPT code 13950.)
    - Nose implants
    - Pectoral implants
    - Reduction thyroid chondroplasty
    - Rhinoplasty

- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing (dermabrasion, chemical peel)
- Voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization are considered cosmetic.
- Voice therapy/voice lessons.

35. **Sexual dysfunction –** Penile implants and any related sexual devices, appliances, services or medications for sexual dysfunction.

36. **Special training/treatment** - Sensitivity training, educational training therapy or treatment for an education requirement. Ecological or environmental medical diagnosis and/or treatment.

37. **Spinal treatment -** Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, when such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Vertebral Axial Decompression (VAX-D), Back to Back, Orthotrac Pneumatic Vest, Back Friend, spinal manipulation for Chronic conditions, maintenance, and/or preventive therapy.

38. **Third opinions -** Opinions and consultations beyond the second opinion.

39. **Transplant -** Medical or Hospital services received on behalf of a donor or prospective donor when the recipient of an organ transplant is not a PPHIC Member. There is no coverage for a PPHIC Member acting as a transplant donor to a non-PPHIC Member.

40. **Travel -** Travel, accommodations and oxygen provided while traveling on an airplane whether or not recommended or prescribed by an In-Network Practitioner/Provider.

41. **Vision -** Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedures to alter Refraction; or complications resulting from the procedure.

    Ophthalmological/Vision services provided in connection with the testing of visual acuity or determination of refraction error for the fitting of eyeglasses or contact lenses. The furnishing or replacing of eyeglasses or contact lenses will not be a benefit, except when following cataract surgery including eye exercise therapy. These exclusions only pertain to adult vision services.

    The following items are specifically excluded under this benefit:
    i. Safety glasses required for employment
    ii. Non-prescription glasses and contact lenses
    iii. Tinted contact lenses not used for corrective purposes
    iv. Glass lenses for Members through age 19
    v. Non-prescription sports related protective eye wear.

42. **War-related services -** Services or supplies received as a result of war, declared or undeclared, or international armed conflict.

43. **Weight Loss/Gain Services** - Special diet or food supplement programs, products or medications for weight loss and weight loss programs. Residential Treatment programs for obesity and/or morbid obesity and/or Residential Treatment for weight gain.

44. **Work related injuries -** Work-related injuries and/or illnesses, including those not covered by a workers' compensation policy.

Part VIII. Plan Administration

1. All PPHIC In-Network Practitioners/Providers are independent contracts. In-Network Practitioners/ Providers are not agents of PPHIC, nor is PPHIC or any of its employees, an employee or agent of In-Network Practitioners/Providers. PPHIC shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care through any Plan Practitioner/Provider.

2. You may, for personal reasons, refuse to accept procedures or treatment by an In-Network Practitioner/ Provider. In-Network Practitioner/Providers may regard such refusal to accept their recommendations as incompatible with continuance of the doctor-patient relationship. You will be advised if no acceptable alternative exists for what the doctor believes to be appropriate medical care. If You continue to refuse the recommended treatment, neither PPHIC nor the In-Network Practitioner/Provider will be responsible for treatment of the condition or any services required.

3. The Premium charges for this COC shall be determined by PPHIC, subject to the approval of the applicable state regulatory agencies.
    a. Premium payment is due on or before the first day of the month for which coverage is provided.
    b. Only when Your Premium payment has been received are You entitled to healthcare services under this COC. A Grace Period of 31 days will be allowed.
    c. PPHIC reserves the right to change the total monthly Premium for the health benefits plan upon 60 days written notice, provided such changes are in accordance with the provisions set forth in this COC.

4. PPHIC reserves the right to revise this COC, Summary of Benefits, in accordance with Federal or State regulatory agencies. Such revisions shall be made upon 60 days' advance written notice to the Group.

5. For the initial claim, PPHIC reserves to itself and its designated administrators the right to interpret or construe the terms of this COC, to resolve all questions concerning the status and rights of Subscribers and others under the COC, including, but not limited to, eligibility for benefits, and to make any other determinations it deems reasonable in the administration of the COC, the right to revise this COC, in accordance with state regulatory agencies. This provision does not restrict the ability of a Member to dispute any claim decision including the right to file a complaint, appeal the denial, to have it reviewed externally (when appropriate) or to file a lawsuit. See Section 16, "Member Complaint and Appeal Procedure."

6. Identification cards are issued for the purpose of identification only. If You willfully or knowingly permit another person to use Your identification card, no benefits will be paid for those services and Your coverage will be terminated. The Member identification card issued by Prominence Health Plan pursuant to this COC is for identification purposes only. Possession of an identification card confers no right to services or benefits under this COC, and misuse of such identification card constitutes grounds for termination of coverage. If the Member who misuses the card is the employee, coverage may be terminated for the employee as well as any of the employee's Dependents who are Members. To be eligible for services or benefits under this COC, the holder of the card must be a Member on whose behalf all applicable premium charges under this COC have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this COC shall be charged for such services or benefits at prevailing rates.

7. You are entitled to ask if PPHIC has special financial arrangements with their contracted Provider/ Practitioner that may affect Referral services, such as laboratory tests and hospitalizations that You might need. Information is available upon request, to current, previous and potential plan Member regarding

whether PPHIC contracts include Practitioner/Provider incentive plans that affect the use of referral services.

8. Transfer of Medical Benefits from Prior Plan.
    a. When this COC replaces another policy, and employee or his Dependents were covered on the date the prior policy ended, insurance will become effective under this COC of coverage on the original date of issue even though:
        i. Employee may not be actively at work; or
        ii. Your Dependents may be confined in a Hospital or Skilled Nursing Facility.
    b. The level of benefits provided by this provision for any illness will be reduced by any benefits payable by the prior policy.
    c. Coverage under this provision will be continued until the earliest of:
        i. The date You or Your Dependents are eligible under the other provisions of this COC;
        ii. The date coverage terminates under this COC.

Part IX. Termination of Coverage

1. Group Coverage, including this COC, may be terminated in the following ways:
    a. By PPHIC, if the Group fails to pay the Premium for this COC when due, and if default continues after the Grace Period, the Group and all Members enrolled through the Group may be terminated.
    b. By PPHIC, or the Group, if the Group, or a covered subsidiary, is no longer located in the State of Nevada.

2. A Member's coverage may be terminated in the following ways:
    a. By the Group, if You are no longer eligible for Group coverage.
    b. By PPHIC, if the Group is no longer eligible to have a contract with PPHIC.
    c. By PPHIC, for failure to make payment of Premiums upon 31 days written notice.
    d. The Plan will not terminate or rescind coverage once a Member is enrolled unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or unless the individual makes a material misrepresentation of fact as prohibited by the terms of the Certificate of Coverage. The Plan will provide at least 30 days advance written notice to each Member who would be affected before Plan Coverage will be rescinded.
    e. By Group, Subscriber or PPHIC for any Dependent Member who is no longer eligible for coverage as a Dependent.
    f. By PPHIC, if You willfully and knowingly permit another person to use Your identification card.

Part X. Continuation of Coverage

Your benefits will cease as of the date of termination of coverage except as provided in this section. In the event that coverage terminates because of termination of eligibility, all benefits will automatically cease. We do not cover claims incurred after the termination date, even if the charges are related to illness that began when Member was active.

Termination of Group: Coverage will continue for a Prior Authorized inpatient admission to a Hospital or Skilled Nursing Facility that began prior to the date of termination, if the PPHIC coverage has not been replaced by other Group coverage.

The extension of benefits will continue for the condition under treatment at the date of termination until whichever of the following events occurs first:

a. You have been discharged as an inpatient;
b. The maximum benefit period is reached;
c. Your employment with the Group is terminated;
d. The Group subsequently replaces PPHIC coverage with other Group coverage for which You are eligible; or
e. A period of twelve 12 months from the date of termination has elapsed.

Total Disability: If You are on a leave of absence without pay as a result of being totally disabled because of an injury or illness, and You cannot perform substantially the duties related to Your employment for which you are otherwise qualified, then benefits of this COC will continue to be provided to You and Your dependents (who are otherwise covered by this COC while you are on leave without pay as a result of a total disability, for any injury or illness suffered by you which is not related to the total disability, or for any injury or illness suffered by your dependent (s). Total Disability Benefits while you are on a leave of absence without pay under this COC will continue until the earlier of:

a. The date on which Your employment is terminated;
b. The date on which You obtain another policy of health insurance;
c. The date on which the policy of group health insurance is terminated; or
d. After a period of twelve (12) months in which benefits under this COC are provided to You.

Federal Continuation: If Your coverage has been terminated under this COC, You may be eligible for coverage continuation under Federal requirements.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Groups that are subject to the terms of COBRA. Contact your plan administrator to find out if your Group is subject to the provisions of COBRA. If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier. We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law. We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Third Party Recovery, Subrogation and Reimbursement Payment Condition: The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation: As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement: The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).
This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets: Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other

source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance: If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds: Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death: In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations: It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).
11. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset: If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status: In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation: The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability: In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Part XI. Coordination of Benefits, Third Party Payments and Double Coverage

1. **Nonduplication:** PPHIC will provide You with full healthcare services within the limits of this Evidence of Coverage. PPHIC does not duplicate benefits or provide You with greater benefits than the actual expenses incurred. Benefits under this COC will be reduced to the extent that they are available or that reimbursement is payable under any other certificate or policy covering You whether or not a claim is made for the benefits.

2. **Workers' Compensation:** PPHIC will not pay for benefits for conditions in which coverage is available under the workers' compensation law. PPHIC may arrange, however, to provide access to and treatment for illness or injury. If workers' compensation deems the Member's illness or injury to be non-work related, the Member must go through the workers' compensation appeal process. Before PPHIC will consider payment of the claim, PPHIC must first receive all final determinations from workers' compensation. The Member must still follow the procedures set forth in this COC which include, but are not limited to, accessing care through Plan Practitioners/Providers and obtaining Prior Authorizations.

3. **Other Carrier Continuation of Coverage:** PPHIC will not pay for Hospital care if You are a patient in a Hospital or Skilled Nursing Facility on the date this COC becomes effective, to the extent coverage is provided under any other contract or insurance policy.

4. **Immunosuppressant medications,** specialty drugs, diabetic supplies, nutritional supplements and self-injectables are paid secondary under this COC if the Member has any other pharmacy policy.

5. **Coordination of Benefits:** In cases when a Member is covered under two insurance contracts that provide similar coverage. PPHIC will coordinate benefit payments with the other company. PPHIC will pay its benefits if all State-approved guidelines are followed as stated in this COC which include, but are not limited to, accessing care through Plan Practitioners/ Providers and obtaining Prior Authorizations. Prior to receiving services under Coordination of Benefits, contact the PPHIC Customer Service Department. One company will provide its full benefit as the primary contract. The other company will be designated as the secondary contract, if necessary, to the extent of its benefit. This prevents double payment and overpayment.

   In order to determine which company is primary, the following rules apply:
   a. If the other contract does not have a provision similar to this one, then it is the primary contract.
   b. If the person receiving the benefit is the Subscriber through which, or to which one contract was issued and is only covered as a Dependent on the other contract, the contract under which the person is the Subscriber shall be primary.
   c. If two or more contracts cover the person receiving care as a Dependent, then the contract of the Subscriber whose birthday, month of birth, follows earliest in the Calendar Year shall be primary unless the other contract uses a rule based on the Subscriber's gender and as a result, the contracts do not agree on the order of benefits. In that case, the other contract shall be primary.
   d. If the Dependent is the child of divorced or separated parents, then benefits for the child are determined in the following order:
      i. First, the plan of the parent with custody of the child;
      ii. Then, the plan of the spouse of the parent with custody of the child;
      iii. Finally, the plan of the parent not having custody of the child; and
      Notwithstanding a., b., and c., above, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This

paragraph does not apply with respect to any claim determination period or plan year during which the benefits are actually paid or provided before the entity has that actual knowledge.

e. If none of the above applies, then the contract which has covered You or the person receiving services for the longest time shall be primary.

f. You are required to cooperate with PPHIC in the administration of this provision. If this COC requires that benefits be paid for by another source and You have failed to seek payment from that source, PPHIC will reduce the payments under this COC by the amount to which You are entitled from that source. In some cases, PPHIC may ask You to sign documents or cooperate with Us to seek payment from another source. You are required to cooperate in such cases.

g. None of the above rules as to Coordination of Benefits will serve as a barrier to You first receiving medical services through PPHIC.

h. Prominence Health Plan medical coverage is always secondary to a dental plan for certain services, including services provided by an oral and maxillofacial surgeon.

6. **Medicare Coordination of Benefits (Medicare COB):** This Medicare COB Rule applies when the Member:

a. Has health insurance under this Policy; and is entitled under Medicare Parts A and B, this Medicare COB Rule applies before any other COB provisions of the Policy.

i. Definitions:

01. ADEA Employer - an Employer which is subject to the U.S. Age Discrimination in Employment Act (ADEA); and has 20 or more employees every working day, in 20 or more calendar weeks, during the current or preceding calendar year.

02. Age 65 (as used in the rule) - is at the age attained at 12:01 a.m. on the first day of the month in which the Member's 65th birthday occurs.

03. ESRD - End Stage Renal Disease.

04. Medicare Benefits - benefits for services and supplies which the Member receives or is eligible for under Medicare, Parts A or B.

ii. Effect on Benefits:

If, according to the rules for determining benefits:

01. PPHIC has primary responsibility for the Member's claims, and then PPHIC pays benefits first.

02. PPHIC has secondary responsibility for the Member's claims;

001. First, Medicare benefits are determined or paid; and

002. Then, PPHIC benefits are paid.

Note, for services payable under both plans, the combined PPHIC and Medicare benefits will not exceed 100% of the expense incurred.

b. Rules for determining order of benefits:

i. **For the Subscriber or the Eligible Employee -** If all the following apply, then PPHIC has primary responsibility for Your claims:

01. The Member is age 65 or older;

02. The Member is eligible for Medicare Parts A and B, solely because of age; and

03. The Member is actively employed by an Age Discrimination in Employment Act (ADEA) Employer and has more than 20 employees, which pays all or part of the Premium. The Member is not actively employed by an ADEA Employer, which pays all or part of the Premium, and when the Member is entitled to Medicare Parts A and B, because of age, this PPHIC Plan has secondary responsibility.

c. For a Dependent Spouse - If all of the following apply, PPHIC has primary responsibility for a dependent spouse's claims:

i. The spouse is age 65 or older;

ii. The spouse is eligible for Medicare, Parts A and B, solely because of age; and

iii. The spouse is actively employed by and ADEA employer which pays all or part of the premium.

If the Member is not actively employed by an ADEA employer which pays all or part of the premium, and when the dependent spouse is eligible for Medicare, Parts A and B, because of age, PPHIC has secondary responsibility.

d. For a Disabled Person - PPHIC has primary responsibility for the claims of a Member.

01. Who is eligible for primary Medicare Benefits because he or she is disabled; even if he or she is also eligible for Medicare, Parts A and B, because of age; and

02. Whose employer normally employed 100 or more employees on a typical business day during the previous calendar year;

e. For an Insured Person with End-Stage Renal Disease - PPHIC has primary responsibility for the claims of a Member.

01. Who is eligible for Medicare Benefits because of End-Stage Renal Disease; even if he or she is also eligible for Medicare, Parts A and B, because of age; and

02. Who is in the Waiting Period (up to 3 months) prior to the coordination period or in the coordination period itself;

f. PPHIC has secondary responsibility - For the claims of a Member who is eligible for secondary Medicare benefits solely because of End-Stage Renal Disease after the coordination period has ended.

g. Beginning of Coordination Periods:

01. For Members who started a course of maintenance dialysis or who received a kidney transplant before 1989, the coordination period begins with the earlier of:

001. The first month of dialysis; or

002. In the case of a Member who received a kidney transplant, the first month in which the Member became entitled to Medicare or, if earlier, the first month for which the individual would have been entitled to Medicare benefits if he or she had filed an application for such benefits.

02. For Members other than those specified in Paragraph 1 above, the coordination period begins with the earlier of the first month of entitlement to, or Eligibility for, Medicare Part A, based solely on ESRD.

h. End of Coordination Periods:

i. For individuals who started a course of maintenance dialysis or who received a kidney transplant before December 1989, the coordination period ends with the earlier of the end of the 12th month or dialysis or the end of the 12th month of a transplant. The 12 months of dialysis may be any time from the 9th month through the 12th month of Medicare entitlement, depending on the extent to which the Member was subject to a Waiting Period before becoming entitled to Medicare.

ii. The coordination period for the following individuals ends with the earlier of the 12 months of entitlement to or eligibility for Medicare Part A:

01. Members, other than those who began dialysis or who received a kidney transplant prior to December 1989, who become entitled to, or eligible for, Medicare Part A solely on the basis of ESRD during December 1989 and January 1990.

02. b. Members who become entitled to, or eligible for, Medicare Part A solely on the basis of ESRD after January 1995.

iii. The coordination period ends with the earlier of the end of the 18th month of eligibility for or entitlement to Medicare Part A, for individuals who become entitled to, or eligible for Medicare Part solely on the basis of ESRD from February 1990 through July 1994.

i. The coordination period ends January 1, 1996 for Members who become entitled to, or eligible for, Medicare Part A solely on the basis of ESRD from August 1994 through January 1, 1995.

ii. The coordination period ends with the earlier of the end of the 30th month of eligibility for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who had not completed an 18-month coordination period by July 31, 1997 will have a 30-month coordination period.

Part XII. Member Rights and Responsibilities

1. **Confidentiality of Healthcare Records:** Information from Your medical records and information received from Practitioners/Providers incident to the doctor-patient or Hospital-doctor relationship shall be kept confidential. Except for use incident to bona fide medical research and education or reasonably necessary in connection with the administration of the PPHIC program, such records may not be disclosed without Your consent.

2. **Explanation of Treatment:** You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You have the right to participate with Your In-Network Practitioners/Providers in making decisions about Your healthcare.

3. **Internal Claim and Appeal Procedure:** You have the right to voice complaints or appeals about the organization or the care it provides. You have the right to express Your concerns and problems regarding Your PPHIC overage and benefits. You are encouraged to contact Customer Service at 775-770-9310 or 800-863-7515 with any questions or problems as soon as they arise. PPHIC is committed to providing prompt and responsive service to all Members.

   We have established a Member Complaint and Appeal Procedure to assist You if You have a problem or concern regarding any aspect of PPHIC services. The Complaint and Appeal Procedure is provided in this Certificate of Coverage and is also available upon request from the PPHIC Customer Service Department.

4. **Notice of Claim:** You should not have to make payments for Medically Necessary Covered Services to PPHIC In-Network Practitioners/Providers except for the required Copayments, Calendar Year Deductible or Co-Insurance. If, however, You have paid for services which are covered by this COC. You may be reimbursed providing:
   a. You provide PPHIC with satisfactory evidence that You have properly made such a payment.
   b. You make the request for reimbursement within 12 months of the date of service and provide proof of payment. Requests should be submitted to:
      Prominence Preferred Health Insurance Company, Inc.
      Claims Department
      1510 Meadow Wood Lane
      Reno, Nevada 89502

5. **Healthy Lifestyle:** As a PPHIC Member, You have access to medical care and coverage of medical care as described in this COC. You are encouraged to maintain a healthy lifestyle and to seek medical care when appropriate. You have a responsibility to follow plans and instructions for care that you have agreed to with Your In-Network Practitioners/Providers.

6. **Maintain Appointments:** You have a responsibility to keep the appointment made by or for You with In-Network Practitioners and other Providers of care. If You are unable to keep an appointment, always make an effort to notify the In-Network Practitioner/Provider and cancel at least 24 hours in advance. If You do not show up for a scheduled appointment, You may be financially responsible for the applicable Copayment.

7. **Authorization to Review Records:** By receiving benefits under this COC, You and Your covered Dependents automatically agree to certain conditions. You have a responsibility to supply information (to the extent possible) that the organization and its In-Network Practitioners and providers need in order to provide care.

8. **Health Responsibility:** You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible. You have the right to a candid discussion of appropriate or Medically Necessary treatment options for Your medical conditions, regardless of cost or benefit coverage. You have the right to be treated with respect and recognition of your dignity and right to privacy.

9. **Information:** You have the right to receive information about the organization, its services, Practitioners, Providers and the above rights and responsibilities. To obtain information about Practitioners and Providers who participate with PPHIC, you can call Customer Service at 775-770-9312 or 800-863-7515, or find this information at www.prominencehealthplan.com. You have the right to make recommendations regarding the organization's Member Rights and Responsibilities policies.

   The Member has the responsibility to provide, to the extent possible, information that PPHIC and its Practitioners/Providers need in order to care for them.

   State of Nevada Division of Insurance - Carson City office:
   1818 E. College Pkwy., Suite 103
   Carson City, Nevada 89706
   775-687-0700 or 888-872-3234

   State of Nevada Division of Insurance - Las Vegas office:
   3300 W. Sahara Ave. Suite 275
   Las Vegas, Nevada 89104
   775-486-4009 or 888-872-3234

Part XIII. Mediation and Arbitration Agreement

Dispute Resolution

1. In consideration of the mutual promises set forth herein, the Parties agree that any and all claims described below shall be deemed waived unless submitted first to mediation and, if the matter is not resolved through mediation, to final and binding arbitration.

2. **Mediation**. You and PPHIC (collectively, the "Parties") shall submit any and all disputes, claims or controversies relating to or arising out of this COC to mediation prior to the appointment of any arbitrator. PPHIC will pay the mediator for his or her costs, fees and expenses. The mediation will be administered by the American Arbitration Association ("AAA") under its Commercial Mediation Procedures. The Parties further agree to cooperate with one another in selecting a mediator and in promptly scheduling the mediation proceedings. The Parties covenant that they will participate in the mediation in good faith. All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the Parties, their agents, employees, experts and attorneys, and by the mediator, are confidential, privileged and inadmissible for any purpose, including impeachment, in any arbitration or other proceeding involving the Parties. This rule of confidentiality and inadmissibility does not apply to evidence that is otherwise admissible or discoverable. Such evidence shall not be rendered inadmissible or non-discoverable because it was used in the mediation.

3. If the dispute is not resolved within 45 days from the date of the initial submission of the dispute to mediation (or such later date as the Parties may mutually agree in writing), the dispute shall be submitted to arbitration. The mediation may continue, if the Parties so agree, after the appointment of the arbitrators. Unless otherwise agreed by the Parties, the mediator shall be disqualified from serving as arbitrator in the case. The pendency of mediation shall not preclude either You or PPHIC from seeking provisional remedies in aid of the arbitration from a court of appropriate jurisdiction, and the Parties agree not to defend against any application for provisional relief on the ground that mediation is pending.

4. Arbitration. The Parties agree that any and all disputes, claims or controversies arising out of or relating to this COC shall be submitted to mediation, and if the matter is not resolved through mediation, then it shall be submitted to final and binding arbitration. PPHIC will pay the arbitrator for his or her costs, fees or expenses. Any dispute, claim or controversy arising out of or relating to the COC, including any claim for benefits, statutory violation, breach of fiduciary duty, enforcement, interpretation or validity of claims ("Covered Claims"), including the determination of the scope or applicability of this Mediation/Arbitration Agreement, shall be determined by arbitration in Reno, Nevada before one arbitrator. The arbitration shall be administered by the AAA under its Commercial Arbitration Rules (the "AAA Rules"), and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The Parties agree they are not allowed to litigate a Covered Claim in any court and agree to waive their right to bring any Covered Claims as, or against, a representative or member of a class or collective action, unless all Parties agree to do so in writing. All Covered Claims must be brought on an individual basis.

5. PPHIC agrees to pay for all necessary arbitration fees. In the event that the COC or the Plan's fiduciaries are vindicated in arbitration, they will not be permitted to seek an award of attorneys' fees. You, on the other hand, will be entitled to recover Your attorneys' fees if the arbitrator finds that You have achieved some degree of success on the merits.

6. The parties further agree that, in the event that either seeks relief in a court of competent jurisdiction for a dispute covered by this Mediation/Arbitration Agreement, the other may, at any time within 60 days of the service of the Complaint, require the dispute to be arbitrated. The decision and award of the arbitrator shall be final, binding and enforceable in the courts.

7. Either You or PPHIC may initiate arbitration with respect to the matters submitted to mediation by filing a written demand for arbitration at any time following the initial mediation session or 45 days after the date of filing of the initial written request for mediation, whichever occurs first. The provisions of Part XVI may be enforced by any court of competent jurisdiction, and the party seeking enforcement shall be entitled to an award of all costs, fees and expenses, including attorney's fees, to be paid by the party against whom enforcement is ordered.

8. **Civil Complaint.** The Parties agree that any and all disputes, claims or controversies arising out of or relating to this COC shall first be submitted to mediation, and if the matter is not resolved through mediation, then it shall be submitted to binding arbitration. Only after the arbitrator has made his or her award and the arbitration has concluded, may either Party initiate a civil lawsuit.

Part XIV. Specific Authorization Agreeing to Mandatory Mediation and Arbitration Provision

Both You and PPHIC agree to resolve any and all disputes, claims or controversies arising out of or relating to this COC through mediation, and if the mediation is not successful, through binding arbitration before initiating a civil lawsuit in a court of general jurisdiction.

Arbitration is more informal than a lawsuit in Court. Arbitration uses a neutral arbitrator instead of a judge or jury, allows for more limited discovery than in court, and is subject to very limited review by courts. Arbitrators can award the same damages and relief that a court can award. Any arbitration under this Mediation/Arbitration Agreement will take place on an individual basis; Class Arbitrations and Class Actions are not permitted.

PPHIC and You agree to arbitrate all disputes and claims between us. This Mediation/ Arbitration Agreement is intended to be broadly interpreted. It includes, but is not limited to any dispute, claim or controversy arising out of or relating to the COC, including any claim for benefits, statutory violation, breach of fiduciary duty, enforcement, interpretation or validity of claims ("Covered Claims"), including the determination of the scope or applicability of this Mediation/Arbitration Agreement.

References to PPHIC include our respective affiliates, agents, parents, subsidiaries, employees, predecessors-in-interest, successors and assigns under this COC or prior agreements between the Parties. This Mediation/Arbitration Agreement does not preclude You from bringing issues to the attention of federal, state, or local agencies, including, for example, the Nevada Division of Insurance. Such agencies, if the law allows, may seek relief against PPHIC on Your behalf. You agree that, by entering into this Mediation/Arbitration Agreement, You and PPHIC are each waiving the right to participate in a class action. This Mediation/Arbitration Agreement evidences a transaction in interstate commerce, and thus the Federal Arbitration Act governs the interpretation and enforcement of this Mediation/Arbitration Agreement. This Mediation/ Arbitration Agreement shall survive termination of this COC.

Notice of a Dispute

A Party who intends to seek mediation or arbitration must first send to the other, by certified mail, a written notice of dispute ("Notice"). The Notice to PPHIC should be addressed as indicated in Part XIV.6. The Notice must (a) describe the nature and basis of the claim or dispute; and (b) set forth the specific relief sought ("Demand"). If PPHIC and You do not reach an agreement to resolve the claim within 30 days after the Notice is received, You or PPHIC may immediately commence a mediation proceeding. The mediation will be administered by the American Arbitration Association ("AAA") under its Commercial Mediation Procedures. If the mediation is not successful, either You or PPHIC may initiate arbitration with respect to the matter submitted to mediation by filing a written demand for arbitration at any time following the initial mediation session or 45 days after the date of filing of the initial written request for mediation, whichever occurs first. The arbitration will be administered by the AAA under its Commercial Arbitration Rules (the "AAA Rules"), and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Arbitration Procedure and Rules

The arbitrator is bound by the terms of this Mediation/Arbitration Agreement. All issues are for the arbitrator to decide, except that issues relating to the scope and enforceability of the Mediation/ Arbitration Agreement are for a federal court to decide. Unless PPHIC and You agree otherwise, any arbitration hearings will take place in Reno, Nevada. If Your claim is for $10,000 or less, the Parties agree that You may choose whether the arbitration will be conducted solely on the basis of documents submitted to the arbitrator, through a telephonic hearing, or by an in-person hearing as established by the AAA Rules. If Your claim exceeds $10,000, the right to a hearing will be determined by the AAA Rules. Regardless of the manner in which the arbitration is

conducted, the arbitrator shall issue a reasoned written decision sufficient to explain the essential findings and conclusions on which the award is based. Except as otherwise provided for herein, PPHIC will pay all AAA filing, administration, and arbitrator fees for any arbitration initiated in accordance with the Notice requirements above. The arbitrator may award declaratory or injunctive relief only in favor of the individual party seeking relief and only to the extent necessary to provide relief warranted by that party's individual claim.

YOU AND PPHIC AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. FURTHER, UNLESS BOTH YOU AND PPHIC AGREE OTHERWISE, THE ARBITRATOR MAY NOT CONSOLIDATE MORE THAN ONE PERSON'S CLAIMS, AND MAY NOT OTHERWISE PRESIDE OVER ANY FORM OF A REPRESENTATIVE OR CLASS PROCEEDING. IF THIS SPECIFIC PROVISION IS FOUND TO BE UNENFORCEABLE, THEN THE ENTIRETY OF THIS ARBITRATION PROVISION SHALL BE NULL AND VOID.

Civil Complaint

The Parties agree that any and all disputes, claims or controversies arising out of or relating to this COC shall first be submitted to mediation, and if the matter is not resolved through mediation, then it shall be submitted to binding arbitration. Only after the arbitrator has made his or her award and the arbitration has concluded, may either Party initiate a civil lawsuit.

Notwithstanding any provision in this Mediation/Arbitration Agreement to the contrary, the Parties agree that You may reject this Mediation/Arbitration Agreement by signing the section of the Member Enrollment/Change and Termination Form entitled "Declination of Right to Mediation and Arbitration" or by sending PPHIC written notice to the Notice Address provided above within thirty (30) days of either: (1) the date on which You first receive notice of this COC containing this Mediation/ Arbitration Agreement or (2) the last day of the first annual enrollment period following the date Your first receive notice of this COC containing this Mediation/Arbitration Agreement. Your failure to reject this Mediation/Arbitration Agreement in writing means You agree to arbitrate any dispute between the Parties in accordance with the language of this provision.

IN ADDITION, NOTWITHSTANDING ANY PROVISION IN THIS MEDIATION/ARBITRATION AGREEMENT TO THE CONTRARY, THE PARTIES AGREE THAT IF PPHIC MAKES ANY FUTURE CHANGES TO THIS ARBITRATION PROVISION (OTHER THAN A CHANGE TO THE NOTICE ADDRESS) DURING THE TERM OF THIS MEDIATION/ARBITRATION AGREEMENT, YOU MAY REJECT ANY SUCH CHANGE BY SENDING PPHIC WRITTEN NOTICE WITHIN THIRTY (30) DAYS OF THE CHANGE TO THE NOTICE ADDRESS PROVIDED ABOVE. BY REJECTING ANY FUTURE CHANGE, YOU ARE AGREEING THAT YOU WILL ARBITRATE ANY DISPUTE BETWEEN US IN ACCORDANCE WITH THE LANGUAGE OF THIS PROVISION.

Notice: When a notice is required under this COC, it must be mailed to:

Prominence Preferred Health Insurance Company, Inc.
Customer Service
1510 Meadow Wood Lane
Reno, Nevada 89502

Part XV. General Provisions

1. **Entire Contract:** This COC, Summary of Benefits and any Riders purchased by the Group, the Group Contract, the Group application, the individual enrollment and, if applicable, a health questionnaire constitute the entire Contract between PPHIC, the Group, the Subscriber and enrolled Dependents, and as of the effective date of this COC supersede all other agreements between the parties.

2. **Administration of Contract:** PPHIC reserves to itself and its designated administrators the exclusive right to interpret or to construe the terms of this Plan, to resolve all questions concerning the status and rights of Members and others under the Plan including but not limited to, eligibility for benefits and to make any other determinations it deems reasonable in the administration of the Plan.

3. **Assignment:** This contract is not assignable by the Group or by You without written consent of PPHIC. Benefits payable under the COC shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. However, You may direct, in writing, that benefits payable to You be paid instead to an institution in which You are or were hospitalized, to a provider of medical services or supplies furnished or to be furnished to You, or to a person or entity that has provided or paid for, or agreed to provide or pay for a benefit payable under the COC. Notwithstanding the foregoing, PPHIC reserves the right to make payment directly to the covered person and to refuse to honor such direction and assignment. No payment by PPHIC pursuant to such direction shall be considered recognition by PPHIC of a duty or obligation to pay a provider of medical services or supplies except to the extent PPHIC actually chooses to do so.

4. **Amendment:** PPHIC may amend this COC in accordance with the provisions contained herein.

5. **Litigation for Payment:** You may not sue PPHIC for refusing to pay for services unless You start the suit within 1 year from the date on which the services were provided or requested.

6. **Notice:** When a notice is required under this COC, it must be mailed to:
   Prominence Preferred Health Insurance Company, Inc.
   Customer Service
   1510 Meadow Wood Lane
   Reno, Nevada 89502

   and to the Group and/or You at the most recent address on file with PPHIC. You are required to inform PPHIC of any change of address.

7. **Clerical Error/Return of Overpayment:** Clerical error, whether of the Group or PPHIC in keeping any record pertaining to the coverage provided will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.

If, due to clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Member, if it is requested, the amount of overpayment will be deducted from future benefits payable.

8. **Information:** Information as to how services may be obtained will be furnished to You upon enrollment and may also be obtained upon request from the Customer Service Department.

9. **Subtitles and Gender:** The subtitles included in this COC are provided for the purpose of identification and convenience and are not part of the complete contract. Use of any gender is deemed to include the other gender and, whenever appropriate, the use of the singular is deemed to include the plural, and vice versa.

10. **Severability:** The provisions of this COC are severable, and if any provision is held to be invalid, illegal or otherwise unenforceable, in whole or in part, that provision shall not affect in any way the remaining provisions of this COC.

11. This COC shall be governed by and construed in accordance with the laws of the State of Nevada and by any applicable federal statutes.

12. **Payment of Interest When a Claim Is Not Paid Timely:** if the claim is approved, it must be paid within 30 days. If the approved claim is not paid within that period, interest on the claim must be paid at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

Part XVI. Internal Claims and Appeal Procedures

The following Internal Claims and Appeal Procedures have been developed to assure a timely and appropriate response to a Member's concerns. Additionally, PPHIC will take into account the clinical urgency of the situation as it relates to the timeliness of responding to Complaints and Appeals. The PPHIC Customer Service Department is available between 8 a.m. and 5 p.m. Monday through Friday at 775-770-9313 or 800-863-7515 to assist the Member.

Benefit Determinations: For purposes of these claims procedures, a claim is any request for Plan benefits.

Definitions

1. **Adverse Benefit Determination:** A determination by PPHIC that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet PPHIC requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated

2. **Appeal:** A written request to PPHIC to change an Adverse Benefit Determination.

3. **Inquiry:** Any communication that has not been subject to an Adverse Benefit Determination and that requests redress concerning an action, a failure to act, or questions a Plan interpretation by PPHIC.

Types of Claims

1. **Pre-Service Claim:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

2. **Post-Service Claim:** Any claim that is not a "Pre-Service Claim."

3. **Concurrent Claim:** An ongoing course of treatment previously approved for a specific period of time or number of treatments.

4. **Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:
    - Jeopardize the life of the covered person;
    - Jeopardize the ability of the covered person to regain maximum function;
    - Cause the covered person to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
    - **In the case of a pregnant woman, cause serious jeopardy to the health of the fetus(es).**

5. **Prior Authorization (Pre-Service) Claims**
   Prior Authorization (Pre-Service) Claims are those that require approval by PPHIC prior to receiving medical care. Prior Authorization requests may be required with PPHIC before medical care is received. If Your claim is a pre-service claim, PPHIC will notify You (or Your authorized representative) of the claim decision within 15 calendar days after receipt of the claim, unless matters beyond the control of PPHIC require an extension of time, in which case, PPHIC has up to an additional 15 calendar days for processing the claim. If an extension of time for processing is required, notice of the extension will be furnished to You before the end of the initial 15-day period. This notice of extension will describe the circumstances necessitating the additional time and the date by which PPHIC is to render its decision.

   If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and You (or Your authorized representative) will have 45 days to provide the specified information to PPHIC after receiving the notice. If all of the needed information is

received within the 45-day time frame, PPHIC will notify You of the decision within 15 days after the information is received.

If You (or Your authorized representative) fail to follow the Plan's procedures for filing a Pre-Service Claim, PPHIC will notify You (or Your authorized representative) of the failure and describe the proper procedures for filing within 5 calendar days (or 72 hours in a case involving Urgent Care, as defined above) after receiving the claim. This notice may be provided orally, unless You (or Your authorized representative) request written notification.

6. **Concurrent Care Claims**
   If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend treatment involves Urgent Care (as defined above), Your request will be decided within 72 hours. PPHIC will make a determination on Your request for the extended treatment within 72 hours from receipt of Your request. If Your request to extend a course of treatment beyond the period of time or number of treatments previously approved does not involve Urgent Care, the request will be treated as a new benefit claim and decided within the time frame appropriate to the type of claim (i.e. pre-service or post-service).

How to File a Claim
In order to file a claim, a Member must either download a copy of the claim form from our website http://www.prominencehealthplan.com or request a claim form from the Subscriber's employer or from PPHIC within 20 days after charges are incurred, or as soon as reasonably possible.

PPHIC will send the claim form to the Member within 15 days after receiving the request. PPHIC will have the right, at its own expense, to physically examine any Member whose illness or injury is the basis of a claim. This may occur when and as often as PPHIC may reasonably require.

Where to Send a Claim
Send completed claim forms and the original bills to:
Prominence Preferred Health Insurance Company
1510 Meadow Wood Lane
Reno, Nevada 89502
t: 775-770-9313 or 800-863-7515
Hours of Operation: 8 a.m. - 5 p.m., Monday - Friday

Payment of Claim
All benefits will be paid to the Member, or with written direction to the provider of medical services. Any payment made under this option will completely discharge PPHIC from any further obligation. PPHIC reserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the Member and to any assignees. Such actions will be binding on the Member and on his assignees.

When a Claim is Denied
Every notice of an Adverse Benefit Determination, or denial of claim, will be set forth in a manner designed to be understood by You, will be provided in writing or electronically, and will include all of the following information that pertains to the determination:

i. A notice of Adverse Benefit Determination will include information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), and a statement notifying the claimant that they may request their diagnosis and treatment code(s) as well as the code's corresponding meaning(s). PPHIC will provide such codes and corresponding meanings as soon as practicable after receipt such requests. Requests for diagnosis and treatment

code(s) and corresponding meaning(s) are merely information requests and will not trigger the start of an internal appeal or external review,

ii. The specific reason or reasons for the claim denial;

iii. Reference to the specific plan provisions upon which the determination is based;

iv. A statement that You may request access to, and copies of, all documents, records and all other information relevant to Your claim;

v. If an internal rule, guideline, standard, protocol, or other similar criterion was relied upon in denying Your claim, a statement that a copy of such rule, etc., will be provided free of charge upon request;

vi. If the denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

vii. An explanation of the plan's review procedures and the time limits applicable to such procedures, including a statement of Your right to bring civil action under Section 502(a) of ERISA following a denial on Appeal, and;

viii. In the case of a claim involving Urgent Care, a description of the expedited review process applicable to such claim.

Para obtener asistencia en Español, llame al: 775.770.9312 / (800) 433-3077. Los avisos están también dis ponibles en Español a petición.

Resolving Complaints

PPHIC will do its best to resolve any questions or concerns You may have on Your initial contact. If it needs more time to review or investigate Your concern, PPHIC will get back to You as soon as possible, but in any case within 30 calendar days for all non-Urgent Care claims. If You are not satisfied with the results of a coverage decision, You can begin the Internal Appeals procedure.

Internal Appeals of Denied Claims

a. Appealing a Denied Claim for Plan Benefits

An Appeal is defined as a Member's request for Prominence Health Plan to change an Adverse Benefit Determination.

How to File an Appeal

To initiate an Appeal, you (or your authorized representative) must submit a request for an Appeal, in writing, outlining the reason for the appeal, and including clinical or other information to Prominence Health Plan within 180 calendar days after notification of your denial notice.

Send completed written Appeals to: Prominence Preferred Health Insurance Company, Inc., 1510 Meadow Wood Lane, Reno, Nevada 89502.

Urgent Care Claim may be appealed orally. If you have an Urgent Care Claim you want to appeal, or if you have questions about the appeal process, please call 775-770-9310/ 800-863-7515, Hours of Operation: 8 a.m. – 5 p.m., Monday through Friday. If you believe that your appeal qualifies as an Urgent Care Claim, you should also inform Preferred that you believe your appeal should be expedited.

Failure to Appeal a denial within the 180-day period, Prominence Health Plan initial claim determination would be final and binding. If you are physically incapacitated during the Appeal timeline and your authorized representative was unable to submit the Appeal on your behalf, then you are entitled to an additional 60 days to submit your Appeal. Upon request, Prominence Health Plan will assign the Appeal's Department to assist you (or your Representative) through the appeal process. The Appeal's Department will review the Appeal.

If you Appeal, you (or your authorized representative) may submit written comments, documents, records, or other information relating to the appeal and the Appeal's Department will re-examine all facts and make a determination with respect to the denial.

As a Prominence Health Plan Member,

i. You may request reasonable access to, and copies of, all documents, records, and other information relevant to your appeal, free of charge.
ii. You may request reasonable access to all documents submitted on your behalf to the Appeal's Department.
iii. You may also obtain a copy of the benefit provisions, guidelines, protocols, or other similar criterion on which the Appeal decision was based.

In order to ensure the prompt and fair processing of Member Appeals, the time-period for filing Appeals and reviewing Appeals is fixed. The beginning date for Member Appeals is that date on which Prominence Health Plan receives notification of a Member's Appeal and ends on the date Prominence Health Plan notifies the Member of its decision. Given the tight time schedules established in the claims procedures, Prominence Health Plan can extend time deadlines. Additional materials submitted after the time has expired for submitting your Appeal cannot be considered.

b. Appeal

Your Appeal will be fully investigated and the substance of the Appeal reviewed. The decision will be made by an individual not involved in the initial denial of your claim nor the subordinate of such individual. The Appeal's Department will consult with an appropriate healthcare practitioner, in the same or a similar specialty, who was not involved in the initial denial of your claim with respect to Appeal involving medical judgment. The Appeal's Department will not afford deference to the initial claim denial.

In the event new or additional evidence is considered, relied on, or generated by the Plan or Appeal's Department in connection with a Member's claim, then as soon as possible, and at least 14 calendar days in advance of the date of the Appeal's Department decision, the Member will be provided, free of charge, with the new evidence or the new rationale. A Member may respond to the new evidence or rationale before a decision is made by the Appeal's Department. Member, or Member's designated representative may appear in person or by teleconference to present information.

Prominence Health Plan will provide written or electronic notification of its decision within 30 calendar days after it receives a pre-service Appeal and 60 days for a post-service Appeal.

In the case of an Urgent Care Appeal request, Prominence Health Plan may respond orally, followed by written or electronic notification, of its decision no later than three calendar days (72 hours).

Every notice of an Adverse Benefit Determination on Appeal will be set forth in a manner designed to be understood by you, and will include all of the following that pertain to the determination:

i. A notice of Adverse Benefit Determination will include information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), and a statement notifying the claimant that they may request their diagnosis and treatment code(s) as well as the code's corresponding meaning(s). Preferred will provide such codes and corresponding meanings as soon as practicable after receipt of such requests. Requests for diagnosis and treatment code(s) and corresponding meaning(s) are merely information requests and will not trigger the start of an external review.
ii. The specific reason or reasons for the Adverse Benefit Determination on Appeal,
iii. Reference to the specific Plan provisions upon which the determination is based,
iv. A statement that you may request access to, and copies of, all documents, records, and all other information relevant to your claim,

v. If an internal rule, guideline, standard, protocol or other similar criterion was relied upon in denying your claim, a statement that a copy of such rule, etc., will be provided free of charge upon request.

vi. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental treatment or similar Exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request,

vii. A statement describing the next level of Appeals procedures offered by the Plan and your right to obtain information about such procedures, and

viii. A statement of your right to initiate mediation and binding arbitration and if not satisfied with the results in arbitration, to bring a civil action under Section 502(a) of ERISA (if applicable). Para obtener asistencia en Español, llame al: 775-770-9310 / 800-863-7515. Los avisos están también dis ponibles en Español a petición.

c. Conflicts of Interest

We will ensure that we adjudicate all claims and appeals in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be based upon the likelihood that the individual will support a denial of benefits.

1.

Time Limit Taking Legal Action Concerning Denied Benefits

a. No legal action for benefits under the EOC may be brought until You:

i. Have submitted a written claim for benefits (including requests for Authorization) in accordance with the procedures described above, have been notified by Prominence HealthFirst that the claim is denied, have filed a written Appeal in accordance with the Appeal procedure described above; or

ii. The Plan fails to establish and follow its own written procedures unless the failure was (i) de- minimis, (ii) non-prejudicial, (iii) attributable to good cause or matters beyond Prominence HealthFirst's control, (iv) in the context of an ongoing good-faith exchange of information, and (v) not reflective of a pattern or practice of non-compliance. Upon written request, Prominence HealthFirst will provide You with an explanation of its basis for asserting that the circumstances meet the exception. If an external reviewer or a court rejects Your request for immediate review of a claim, on the basis that Prominence HealthFirst met the exception requirements listed above, You have the right to resubmit Your claim and pursue an internal appeal. No legal action may be commenced or maintained against HealthFirst more than one (1) year from the date the appeals committee should have filed its written response to Your appeal of the denied claim.

To file a Complaint with the Secretary to the Consumer Health Assistance You must submit Your Complaint in writing to:

Consumer Health Assistance
555 East Washington Avenue, Suite 4800
Las Vegas, Nevada 89101
t: 702-486-3587 or
t: 888-333-1597
f: 702-486-3586

NOTICE OF APPEAL RIGHTS UNDER NEVADA LAW[1]

You have a right to appeal any decision PPHIC makes that denies payment on Your claim or Your request for coverage of a health care service or treatment.

You may request an additional explanation when Your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment You received was not fully covered. Contact us at 800-863-7515 when You:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in Your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and You want to appeal.

If Your claim was denied due to missing or incomplete information, You or Your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Appeals: All appeals for claim denials (or any decision that does not cover expenses You believe should have been covered) must be sent to Prominence Preferred Health Insurance Company, Inc. Customer Service, 1510 Meadow Wood Lane, Reno, NV 89502, within 180 days of the date You receive our denial. We will provide a full and fair review of Your claim by individuals associated with us, but who were not involved in making the initial denial of Your claim. You may provide us with additional information that relates to your claim and You may request copies of information that we have that pertains to Your claims. We will notify You of our decision in writing within 30 days of receiving Your appeal. If You do not receive our decision within 30 days of receiving Your appeal, You are entitled to file a request for external review.

[1] The Notice of Appeal Rights is also attached as Appendix A.

Emergency Experimental or Investigational Medical Conditions

In the event of emergency experimental or investigational medical conditions, the time frame for completing the expedited review for urgent claims either internally or externally do not apply. Emergency medical conditions are those that would jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function. Review for requests of emergency experimental or investigational medical treatment may be made at the same time a request for an expedited review of a denied claim has been made both internally and externally.

If the initial denial of the claim for emergency experimental or investigational treatment involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and if the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment (the subject of the initial claim denial) would be significantly less effective if not promptly initiated, then the independent review organization assigned to conduct the expedited external review will decide whether the Covered Person will be required to complete the expedited review of the denied claim before medical services are provided.

External Review of Denied Claims

External Review: If we have denied Your request for the provision of or payment for a health care service or course of treatment You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment You requested by submitting a request for external review within four months after receipt of the denial notice to the Office for Consumer Health Assistance, 555 East Washington #4800, Las Vegas, NV 89101, Phone: (702) 486-3587, (888) 333-1597, or Fax (702) 486-3586, Web: http://dhhs.nv.gov/Programs/ CHA/.

For standard external review, a decision will be made within 45 days of receiving Your request. If You have a medical condition that would seriously jeopardize Your life or health or would jeopardize Your ability to regain

maximum function if treatment is delayed, You may be entitled to request an expedited external review of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, You also may be entitled to file a request for an expedited external review of our denial. For details, please review Your Evidence Coverage or Certificate of Coverage, contact us, the Office for Consumer Health Assistance or contact the Nevada Division of Insurance.

Attached as Appendix B are copies of Nevada's External Review Request Forms. These forms must be completed and submitted to the Office for Consumer Health Assistance to initiate an external review of Your denied claim.

Part XVII. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

If you have questions about this notice please contact:
Privacy Officer
Prominence Preferred Health Insurance Company
1510 Meadow Wood Lane
Reno, Nevada 89502
t: (775) 770-9444
f: (775) 770-6253

WHO WE ARE

This Notice describes the privacy practices of PPHIC and applies to any health services the Member receives through PPHIC.

OUR PRIVACY OBLIGATIONS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules to carry out this law (Privacy Rules), require PPHIC to notify participants and beneficiaries about the policies and practices the plan has adopted to protect the confidentiality of their health information, including health care payment information.

This Notice describes the privacy policies of PPHIC. These policies protect medical information relating to the Member's past, present and future medical conditions, health care treatment and payment for that treatment (Protected Health Information or PHI).

This law requires PPHIC to maintain the privacy of the Member's PHI, to provide the Member with this Notice of its legal duties and privacy practices, and to abide by the terms of this Notice. In general, PPHIC may only use and/or disclose the Member's PHI where required or permitted by law or when the Member authorizes the use of disclosure. When we use or disclose (share) the Member's PHI, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides the Member with certain rights described in this Notice.

WHEN PPHIC MUST DISCLOSE A MEMBER'S PHI

PPHIC must disclose the Member's PHI:

1. To the Member;
2. To the Secretary of the United States Department of Health and Human Services (DHHS) to determine whether the Plan is in compliance with HIPAA; and
3. Where required by law. This means PPHIC will make the disclosure only when the law requires it to do so, but not if the law would just allow it to do so.

HOW WE PROTECT YOUR PHI

PPHIC protects PHI in the following ways:

1. Digital security measures, including password protection, restricted user access and file encryption.
2. Physical security measures, including locked filing systems, lock boxes, building access security and building security alarms.
3. Staff is trained not to discuss member personal information outside of secure work areas.

WHEN PPHIC MAY USE OR DISCLOSE MEMBER'S PHI WITHOUT THE MEMBER'S AUTHORIZATION

PPHIC may use and/or disclose the Member's PHI as follows:
In many situations, we can use and share the Member's PHI for activities that are common in many hospitals and clinics. In certain other situations, which are described herein, we must have the Member's written permission (authorization) to use and/or share the Member's PHI. We do not need any type of permission from the Member for the following uses and disclosures:

For Treatment. PPHIC does not provide medical treatment directly, but it may disclose the Member's PHI to a health care provider who is giving treatment. For example, PPHIC may disclose the types of prescription drugs the Member currently take to an emergency room Practitioner, if the Member is unable to provide the Member's medical history due to an accident. In addition, we may contact the Member to tell the Member about other health-related benefits and services that might interest the Member.

For Payment. PPHIC may use and disclose PHI, as needed, to pay for the Member's medical benefits. For example, PPHIC may tell a doctor whether the Member is eligible for coverage or what percentage of the bill PPHIC might pay. PPHIC may also use or disclose the Member's PHI in other ways to administer benefits; for example, to process and review claims, to coordinate benefits with other health plans, including Medicare, or Medicaid, and to do utilization review and pre-authorizations.

For Healthcare Operations. PPHIC may use and disclose the Member's PHI to make sure PPHIC is well run, administered properly and does not waste money. For example, PPHIC may use information about the Member's claims to project future benefit costs or audit the accuracy of its claims processing functions. PPHIC may also disclose the Member's PHI for a claim under a stop- loss or re-insurance plan. Among other things, PPHIC may also use the Member's PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits.

For Special Information. In addition to the Privacy Rule, special protections under state or other Federal law may apply to the use of disclosure of the Member's PHI. PPHIC will comply with these state or federal laws where they are more protective of the Member's privacy.

To the Member's Other Health Care Providers. We may also share PHI with the Member's doctor and other health care providers when they need it to provide treatment to the Member, to obtain payment for the care they give to the Member, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.

To Business Associates. PPHIC may hire third parties that may need the Member's PHI to perform certain services on behalf of the Plan. These third parties are "Business Associates" of the Plan. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, PPHIC. For example, PPHIC may hire a third party administrator to process claims, an auditor to review how an insurer or third party administrator is processing claims, or an insurance agent to assess coverage and help with claim problems.

To Individuals Involved with the Member's Care or Payment for the Member's Care. PPHIC may disclose the Member's PHI to adult members of the Member's family or another person identified by the Member who is involved with the Member's care or payment for the Member's care if: 1) the Member authorize PPHIC to do so; 2) PPHIC informs the Member that it intends to do so and the Member do not object; or 3) PPHIC infers from the circumstances, based upon professional judgment, that the Member do not object to the disclosure. Whenever possible, PPHIC will try to get the Member's written objection to these disclosures (if the Member wish to object), but in certain circumstance it may rely on the Member's oral agreement or disagreement to disclosures to family members.

To Personal Representatives. PPHIC may disclose the Member's PHI to someone who is the Member's personal representative. Before PPHIC will give that person access to the Member's PHI or allow that person

to take any action on the Member's behalf, it will require him/her to give proof that he/she may act on the Member's behalf; for example, a court order or power of attorney granting that person such power.

Generally, the parent of a minor child will be the child's personal representative. In some cases, however, state law allows minors to obtain treatment (e.g., sometimes for pregnancy or substance abuse) without parental consent, and in those cases PPHIC may not disclose certain information to the parents. PPHIC may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.

For Treatment Alternatives or Health-Related Benefits and Services. PPHIC may contact the Member to provide information about treatment alternative or other health-related benefits or services that may be of interest to the Member.

For Public Health Purposes. PPHIC may:

1. Report specific disease or birth/death information to a public health authority authorized to collect that information;
2. Report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
3. Report reactions to medication or problems with medical products to the Food and Drug Administration to help ensure the quality, safety, or effectiveness of those medications or medical products; or
4. If authorized by law, disclose PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or medical condition.

To Report Violence and Abuse. PPHIC may report information about victims of abuse, neglect or domestic violence to the proper authorities.

For Health Oversight Activities. PPHIC may disclose PHI for civil, administrative criminal investigations, oversight inspections, licensure or disciplinary actions (e.g., to investigate complaints against medical providers), and other activities for the oversight of the health care system or to monitor government benefit programs.

For Lawsuits and Disputes. PPHIC may disclose PHI to an order of a court or administrative agency, but only to the extent expressly authorized in the order. PPHIC may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if PPHIC has received adequate assurances that the information to be disclosed will be protected. PPHIC may also disclose PHI in a lawsuit if necessary for payment or health care operations purposes.

For Law Enforcement. PPHIC may disclose PHI to law enforcement officials for law enforcement purposes and to correctional institutions regarding inmates.

To Coroners, Funeral Directors and Medical Examiners. PPHIC may disclose PHI to a coroner or medical examiner; for example, to identify a person or determine the cause of death. PPHIC may also release PHI to a funeral director that needs it to perform his or her duties.

For Organ Donations. PPHIC may disclose PHI to organ procurement organizations to facilitate organ eye or tissue donations.

For Limited Data Sets. PPHIC may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

To Avert Serious and Imminent Threats to Health or Safety. PPHIC may disclose PHI to avert a serious and imminent threat to the Member's health or safety or that of members of the public.

For Special Governmental Functions. PPHIC may disclose PHI to authorized federal officials in certain circumstances. For example, disclosure may be made for national security purposes or for members of the armed forces if required by military command authorities.

For Workers' Compensation. PPHIC may disclose PHI for workers' compensation if necessary to comply with these laws.

For Research. PPHIC may disclose PHI for research studies, subject to special procedures intended to protect the privacy of the Member's PHI.

For Emergencies and Disaster Relief. PPHIC may disclose PHI to organizations engaged in emergency and disaster relief efforts.

As Required By Law. We may use and share the Member's PHI when required to do so by any other law not already referred to above.

Written Authorization. In all other situations PPHIC will not use or disclose the Member's PHI without the Member's written authorization. The authorization must meet the requirements of the Privacy Rules. If the Member gives PPHIC a written authorization, the Member may cancel the Member's authorization, except for uses or disclosures that have already been made based on the Member's authorization. Written "revocation" statements must be submitted to our Privacy Officer at the address listed above. The Member may not, however, cancel the Member's authorization if it was obtained as a condition for obtaining insurance coverage and if the Member cancellation will interfere with the insurer's right to contest the Member's claims for benefits under the insurance plan. PPHIC may condition the Member's enrollment or eligibility for benefits on the Member's signing an authorization, but only if the authorization is limited to disclosing information necessary for underwriting or risk rating determinations needed for PPHIC to obtain insurance coverage.

Highly Confidential Information. Federal and state laws require special privacy protections for certain highly confidential information about the Member ("Highly Confidential Information"), including any portion of the Member's PHI that is: (1) kept in psychotherapy notes; (2) about mental health and developmental disabilities services; (3) about alcohol and drug abuse prevention, Treatment; (4) about HIV/AIDS testing, diagnosis or Treatment; (5) about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; (9) about sexual assault; or (10) In Vitro Fertilization (IVF) Before we share the Member's Highly Confidential Information for a purpose other than those permitted by law, we must obtain the Member's written permission.

For Marketing. We must also obtain the Member's written permission (authorization) prior to using the Member's PHI to send the Member any marketing materials. However, we may communicate with the Member about products or services related to the Member's Treatment, case management, or care coordination, or alternative treatments, therapies, health care providers, or care settings without the Member's permission. For example, we may not sell the Member's PHI without the Member's written authorization.

THE MEMBER'S INDIVIDUAL RIGHTS

The Member has certain rights under the Privacy Rules relating to the Member's PHI maintained by PPHIC. All requests to exercise those rights must be made in writing to the Privacy Official. PPHIC's insurers and HMO's keep their own records and the Member must make the Member's requests relating to the Member PHI in those records directly to that insurer or HMO. The Member's rights are:

Right to Request Restrictions on Uses and Disclosures of the Member's PHI. The Member may request that PPHIC restrict any of the permitted uses and disclosures of the Member's PHI listed above.

PPHIC, however, does not always have to agree to the Member's requested restriction. A restriction cannot prevent use or disclosures that are required by the Secretary of DHHS to determine or investigate PPHIC's compliance with the Privacy Rules, or that are otherwise required by law. PPHIC must grant the Member's request to a restriction on disclosure of the Member's PHI to a health plan if the Member has paid for the health care item in full out of pocket.

Right to Access or Copy the Member's PHI. The Member generally has a right to access the Member's PHI that is kept in PPHIC' records, except for; 1) psychotherapy notes (as defined in the Privacy Rules); or 2) information complied in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Member may, under some circumstance, request a review of that denial. PPHIC may charge the Member a reasonable fee for copying the information the Member request and the cost of any mailing, but cannot charge the Member for time spent finding and assembling the requested information.

Right to an Accounting of Disclosures. At the Member's request, PPHIC must provide the Member with a list of PPHIC' disclosures of the Member's PHI made within the six-year period just before the date of the Member's request, except disclosures made:

1. For purposes of treatment, payment or health care operations;
2. Directly to the Member or close family members involved in the Member's care;
3. For purposes of national security;
4. Incidental to otherwise permitted or required disclosures;
5. As part of a limited data set;
6. To correctional institutions or law enforcement officials;
7. With the Member's express authorization.

The Member may request one accounting, which PPHIC must provide at no charge, within a single 12-month period. If the Member request more than one accounting within the same 12-month period, PPHIC may charge the Member a reasonable fee.

Right to Amend. The Member may request that PPHIC change the Member's PHI that is kept in PPHIC's records, but PPHIC does not have to agree to the Member's request. PPHIC may deny the Member's request if the information in its records: 1) was not created by PPHIC; 2) is not part of PPHIC' records; 3) would not be information to which the Member would have right of access; or 4) is deemed by PPHIC to be complete and accurate as it then exists.

Right to Request Restrictions and Confidential Communications. The Member has the right to request that PPHIC communicate with the Member in a confidential manner, for example, by sending information to an alternative address or by an alternative means. PPHIC will accommodate any reasonable request, though it will require that any alternative used must still allow for payment information to be effectively communicated and for payments to be made.

Right to Request Restrictions on Uses and Disclosures of the Member's PHI. The Member may request that PPHIC restrict any of the permitted uses and disclosures of the Member's PHI listed above. PPHIC, however, does not always have to agree to the Member's requested restriction. A restriction cannot prevent use or disclosures that are required by the Secretary of DHHS to determine or investigate PPHIC' compliance with the Privacy Rules, or that are otherwise required by law. We must grant the Member's request to a restriction on disclosure of the Member's PHI to a health plan if the Member have paid for the health care item in full out of pocket.

Right to File a Complaint. If the Member believe the Member's rights have been violated, the Member have a right to file a written complaint with PPHIC' Privacy Official or with the Secretary of the DHHS. PPHIC will not retaliate against the Member for filing a complaint and cannot condition the Member's enrollment or the Member's entitlement to benefits on the Member's waiving these rights. If the Member's complaint is with an insurer or HMO, the Member may file a complaint with the individual named in their Notice of Privacy Practices to receive complaints. If the Member's complaint is with PPHIC, the Member may submit the Member's complaint to the Privacy Official at the address at the end of this Notice.

The Member may also send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. PPHIC Facility Privacy Office can provide the Member the address. PPHIC will not take any action against the Member for filing a complaint. To file a complaint with the Secretary of the DHHS, the Member must submit the Member's complaint in writing, either on paper or electronically, within 180 days of the date the Member knew or should have known that the violation occurred. The Member must state who the Member are complaining about and the acts or omissions the Member believe are violations of the Privacy Rules.

Right to Receive a Paper Copy of This Notice upon Request. The Member has a right to obtain a paper copy of this Notice upon request. To request a paper copy of the Notice, contact the PPHIC Privacy Official.

HEALTH INFORMATION NOT COVERED BY THIS NOTICE.

This Notice does not cover:

1. Health information that does not identify the Member and with respect to which there is no reasonable basis to believe that the information could be used to identify the Member; or
2. Health information that PPHIC can have under applicable law e.g., the Family and Medical Leave Act, the Americans with Disabilities Act, worker's compensation, federal and state occupational health and safety laws, and other state and federal laws), or that the Company properly can get for employment related purposes through sources other than PPHIC and that is kept as part of the Member's employment records (e.g., pre-employment physicals, drug testing, fitness for duty examinations, etc.).

Changes to the Notice. PPHIC reserves the right to change the terms of this Notice to make the new revised Notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan before the date of the revised Notice. If the Member agrees, PPHIC may provide the Member with a revised Notice electronically. Otherwise, PPHIC will provide the Member with a paper copy of the revised Notice. In addition, PPHIC will post the revised Notice on its website used to provide information about PPHIC' benefits.

Complaints. If the Member believes that PPHIC has violated the Member's privacy rights, are concerned that we have violated the Member's privacy rights, or disagree with a decision that we made about access to the Member's PHI, the Member may file a complaint with PPHIC or with the Secretary of the Department of Health and Human Services. To file a complaint with PPHIC, the Member must submit the Member's complaint in writing to:

Privacy Officer
Prominence Preferred Health Insurance Company
1510 Meadow Wood Lane
Reno, Nevada 89502
t: (775) 770-9444