Prominence Preferred Health Insurance Company, Inc.

YOUR LARGE GROUP EVIDENCE OF COVERAGE

This is Your Evidence of Coverage (EOC) with Prominence Preferred Health Insurance Company, Inc. (hereinreferred to as "Prominence"), 1510 Meadow Wood Lane, Reno, Nevada, 89502, (800) 863-7515.

This EOC is provided to each Subscriber who has enrolled in Prominence through a Group Contract and contains important information about your plan. The EOC, Schedule of Benefits, Your enrollment form and identification card become the contract between You and Prominence. By enrolling in Prominence and accepting this EOC, You agree to abide by the rules as described in this EOC. This EOC is provided upon enrollment, upon Your renewal and upon request.

Members are eligible to receive Medically Necessary Covered Services and benefits described in this EOC in exchange for the Premium paid to Prominence. Please keep these materials handy so You can refer to them for information about Your Plan coverage.

The best way to take full advantage of Your Plan benefits is to familiarize Yourself with Your coverage. As a Prominence Member, You are entitled to receive the services and benefits described in this EOC. This booklet contains a description of the Prominence benefits and services available to You. Information about Copayments, Coinsurance, Deductibles, and any applicable optional benefits which may be available to You are included in the Schedule of Benefits.

The Subscriber is free to be treated by any Provider he or she chooses. Whether or not the Provider is a Plan Provider will determine the amount of reimbursement. Please refer to Your Schedule of Benefits for Copayments, Deductibles, Coinsurance, and limitations.

If You have questions about this EOC, please call Prominence Customer Service at (800)863-7515 or (TTY Operator Assistance) (800)326-6868. Our website, ProminenceHealthPlan.com, also serves as an important resource for Your EOC, 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 Customer Service at (800)863-7515 and they can assist You with access to language translation services. You can also contact Prominence 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 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 ProminenceHealthPlan.com or ProminenceMember.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 Plan ID number located on Your identification card.
- Visit ProminenceHealthPlan.com or ProminenceMember.com.

Select "Create an account" and follow the prompts. Once the login process has verified Your demographics, Your login and password will be issued, and You will have access to the online self-service benefit information.

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

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

Download our My PHP Mobile app from the iPhone App Store or Android Google Play Store today!

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Abbreviations Key

ADEA - Age Discrimination in Employment Act

COB - Coordination of Benefits

COE - Center of Excellence

DME - Durable Medical Equipment

EOC - Evidence of Coverage

ERISA - Employment Retirement Income Security Act

ESRD - End Stage Renal Disease

FDA - U.S. Food and Drug Administration

OCHA - Office of Consumer Health Assistance

PCP - Primary Care Provider

PHSA - Public Health Services Act

PPO - Preferred Provider Organization

QI - Quality Improvement

TMJ - Temporomandibular Joint Disorder

TPN - Total Parenteral Nutrition

UCR – Usual, Customary and Reasonable

UM - Utilization Management

Para obtener asistencia en Español, llame al: (775)770-9310 / (800)863-7515. Los avisos están también disponibles en Español a petición.

Part I. Definitions

1. **Accessibility** - the extent to which a Member 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 EOC 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. **Accidental Dental Injury** - a bodily Injury which can be seen or felt by a Physician, or which shows up on an x-ray or other diagnostic-imaging device. The bodily Injury must have been caused by an accident. Accidental Dental Injury does not mean bodily Injury caused by routine body movements such as stooping, twisting, bending, or chewing and does not include damage to appliances or prosthetic devices.
4. **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.
5. **Acute** - an Illness or Injury of short duration and generally of sudden onset and infrequent occurrence.
6. **Adverse Benefit Determination** - a determination made by Prominence which includes but is not limited to a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or a failure to provide or make a payment (in whole or in part) for a benefit that is based on, among other things:
    - A determination that an individual is not eligible for coverage (e.g., Rescission), or
    - The refusal to pay a claim, in whole or in part, due to the terms of coverage document regarding Deductibles, Copayments, Coinsurance, or other cost sharing requirements.
7. **Allowed Amount** – the contracted amount for a Covered Service or, if there is not a contracted amount, UCR. In the case of Emergency Services, the Allowed Amount shall be increased, as applicable, to comply with state and federal law.
8. **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.
9. **Anorexia Nervosa** - a condition characterized by a refusal to maintain a minimally normal body weight.
10. **Appeal** - a written request to Prominence to change an Adverse Benefit Determination.
11. **Authorization** - the process by which an In-Network Provider must justify the need for delivering a Covered Service or medication to a Medical Plan Member and obtain approval from the Medical Plan before 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.
12. **Authorized Representative** - a person you designate through express written consent to assist or handle affairs related to your health care services. This may be someone you designate as a Power of Attorney, a family member, friend, caregiver, attorney, or an advocate you assign to assist with an exception, appeal or grievance.
13. **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.

14. **Availability** - the extent to which the Medical Plan has Providers of the appropriate type and number distributed geographically to meet the needs of its membership.
15. **Balance Billing** – when an Out-of-Network Provider bills You for the difference between the Provider's charge and the Allowed Amount. For example, if the Out-of-Network Provider's charge is $50 and the Allowed Amount is $30, the Provider may bill You for the remaining $20. An In-Network Provider may not Balance Bill You for Covered Services. Out-of-Network Providers are prohibited from collecting an amount for Medically Necessary Emergency Services that exceeds the In-Network Copayment, Coinsurance or Deductible required by this EOC. Out-of-Network Providers who provide services at In-Network facilities in non-Emergency situations are prohibited from collecting an amount for Medically Necessary services that exceeds the In-Network Copayment, Coinsurance or Deductible required by this EOC, unless proper advance notice is provided, and consent is given by the Member.
16. **Bariatric Restrictive Services** - includes various surgical interventions to accomplish weight-loss reduction in individuals who meet the criteria.
17. **Benefit** - the amount payable in accordance with the provisions of this plan.
18. **Bereavement Services** - care extended to the surviving family Members of a deceased person to help them navigate through the grieving process following the loss of a loved one. Bereavement Services generally include counseling and educational support to survivors through visits, phone calls, letter contact, or through support groups.
19. **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.
20. **Calendar Year** - the 12-month period beginning January 1 and ending December 31.
21. **Cardiac Rehabilitation Services** - Phase I and Phase II includes inpatient cardiac monitored services; programs are physician ordered and supervised.
22. **Centers of Excellence (COE)** - an approved Center of Excellence (COE) is a health care facility or other Provider that provides highly specialized care to Members with certain health conditions. COE partner facilities or Providers must meet Prominence 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 Provider. As designated COE Providers may be located out of the 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 ProminenceHealthPlan.com.
23. **Chelation Therapy** - the treatment and removal of lead poisoning or other heavy metal poisoning from the body.
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 the Allowed Amount that a Member must pay a Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the Provider who bills for the Covered Services.
26. **Complaint** - an oral or written expression of dissatisfaction from a Member or 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, MRI and CT Scans, and SPECT Scans. This category of imaging does not include screening and diagnostic mammography, x-ray, ultrasound, 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 woman's doctor are covered. Self-administered hormonal contraceptives that utilize a hormone and are approved by the FDA, including oral contraceptives, vaginal rings, and contraceptive patches, are covered without a prescription if dispensed by a pharmacist in Nevada in compliance with Senate Bill 190 (2021).
31. **Coordination of Benefits (COB)** - a process by which another health plan (if the Member is enrolled on both this Plan and another 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 Provider at the time the services are received. These Copayments are described in the Schedule of Benefits, a separate document, which is supplied to the Subscriber.
33. **Cosmetic** - procedures or medications 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. **Cosmetic Dentistry** - services that are provided by a Dentist primarily for the purpose of improving appearance.
35. **Course of Treatment** - an interdependent series of Medically Necessary Covered Services prescribed by a Provider to treat a specific condition.
36. **Covered Services** - those Medically Necessary medical and Hospital services described in this EOC that are provided to Members for the purpose of preventing, alleviating, curing, or healing Illness or Injury. **While Covered Services must always be Medically Necessary, not every Medically Necessary service is a Covered Service.**
37. **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.
38. **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 Member is not changing;
    c. Does not require continued administration by licensed medical personnel; and
    d. Assists in the activities of daily living.
39. **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. Copayments and Coinsurance do not count towards the Deductible.
40. **Dental Injury** - an Injury to the jaw, sound natural teeth, mouth, or face as a result of an accident caused by an external force such as a blow or fall. An Injury that results from chewing or biting is not considered an Accidental Dental Injury.
41. **Dentist** - an individual who is duly licensed to practice dentistry or perform oral surgery and is acting within the lawful scope of his or her license.
42. **Dependent** - any Member of the Subscriber's family who meets the eligibility for coverage as defined in this EOC and is enrolled in the plan. The Group determines which category of Dependent is eligible to enroll prior to open enrollment each year.
43. **Developmental Delay** - when a Member has not reached the appropriate level of intellectual, speech, motor or physical development normally expected for the Member's age, and such conditions are not a result of an Injury or Illness.

44. **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 Providers to detect disease earlier, make diagnoses, prescribe therapies, and monitor results. Some diagnostic testing is considered Complex Diagnostic Testing.
45. **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.
46. **Domestic Partner** - an individual who has entered a civil contract that grants the individuals the same rights, protection, benefits, responsibilities, obligations and duties as do parties to any other civil contract.
47. **Durable Medical Equipment (DME)** - equipment Prominence determines 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.
48. **Effective Date** - the date specified by Prominence as the date Members are covered under the terms of this EOC provided the premium has been received by Prominence.
49. **Emergency** - A medical condition manifesting itself by symptoms of sufficient severity that a a prudent person could reasonably believe that 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 an unborn child;
    c. Serious impairment of a bodily function; or
    d. 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.
50. **Emergency Dental Services** - services required for the relief of severe pain or bleeding, and/ or the immediate diagnosis and treatment of an unforeseen dental condition, which, if not treated immediately, would result in serious harm to the dental health of the Member. Coverage for an Emergency is limited to palliative care only.
51. **Emergency Services** - healthcare services that are provided to a Member by a Provider in an Emergency:
    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 Emergency Services from an Out-of-Network Provider, the Provider is prohibited from collecting an amount for Medically Necessary services that exceeds the In-Network Copayment, Coinsurance or Deductible required by this EOC.
52. **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 EOC, whose enrollment form has been accepted by Prominence in accordance with the enrollment requirements of this EOC and for whom premiums have been received by Prominence.
53. **Enteral Nutrition** - the delivery of nutrients by a tube into the gastrointestinal tract.
54. **Evidence of Coverage (EOC)** - this document, the Schedule of Benefits, the Group Enrollment Agreement, the Member's application and any amendments, attachments or endorsements that

may be added in the future, which explain the services and benefits covered by Prominence and defines the rights, responsibilities and accountabilities of the Member and Prominence.

55. **Exclusion** - any item or service that is not a Covered Service under this EOC.
56. **Experimental/Investigational** - a drug, device, medical treatment, or procedure that in Prominence's 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; or
    d. Unless otherwise mandated by State and Federal Statutes.
57. **External Review Organization** - is a medical review performed by an Independent Review Organization or specialist.
58. **Free-standing, Outpatient Facility** - These facilities may provide lab tests, diagnostic tests, radiological testing, and other ambulatory procedures, but is independent from a hospital. When In-Network, these facilities are usually the most cost-effective option for a Member to receive diagnostic and radiological testing.
59. **Gender dysphoria** - means distress or impairment in social, occupational, or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth.
60. **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.
61. **Group** - the employer or other party that has entered a Group Contract with Prominence through which benefits under this EOC are provided to eligible Employees, and the employer has agreed to collect and pay premiums. The Group is not an agent of Prominence but is considered the plan sponsor.
62. **Group Contract** - the agreement between the Group and Prominence through which the Plan coverage for eligible employees and Dependents is elected.
63. **Group Open Enrollment Period** - Those periods of time established by the Group and Prominence during which eligible persons who have not previously enrolled with Prominence may do so. The enrollment period will be established at least once every twelve (12) months.
64. **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.
65. **Hearing aid** - electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver. Hearing aids may be required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).
66. **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 Provider.

67. **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.
68. **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.
69. **Illness or Injury** - A disorder or disease of the body or mind or an accidental bodily wound. All Illnesses or Injuries due to the same cause or to a related cause are considered one Illness or Injury.
70. **Independent Review Organization (IRO)** - an entity that: (a) conducts an independent external review of an Adverse Benefit Determination; and (b) is certified by the Nevada Division of Insurance Commissioner to do so.
71. **In-Network** - A term for Providers or facilities that enter into a network agreement with Prominence or a Prominence subcontractor, or the services provided by such Providers. In-Network Providers are also referred to as participating Providers.
72. **Inquiry** - Any communication that has not been subject to an Adverse Benefit Determination and that makes a request concerning an action, a failure to act, or questions a Plan interpretation by Prominence.
73. **Medical Director** - A physician designated by Prominence to monitor appropriate utilization of healthcare services, and quality of care.
74. **Medical Supplies** - Medical Supplies are routine supplies that are customarily used during 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.
75. **Medically Necessary or Medical Necessity** - 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 Prominence or its designee, within Prominence's 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 primarily for Your convenience or that of Your doctor or other health care Provider;
    d. Required to improve Your specific health condition or to preserve Your existing state of health; and

    The most clinically appropriate level of health care that may be safely provided to You.
    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.

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

76. **Medically Necessary Emergency Services** - health care services that are provided by a Provider of health care to screen and to stabilize a Member after an Emergency.
77. **Member** - any Subscriber or eligible enrolled Dependents entitled to benefits under this EOC.
78. **Never Events** - 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:
    a. Serious preventable event - air embolism;
    b. Serious preventable death - blood incompatibility;
    c. Serious preventable event - object left during surgery;
    d. Catheter-associated urinary tract infections;
    e. Pressure (Decubitus) ulcers;
    f. Vascular catheter - associated infection;
    g. Surgical site infection - mediastinitis after coronary artery bypass graft (CABG) surgery; and
    h. Hospital-acquired Injuries - fractures, dislocations, intracranial Injury, crushing Injury, burn and other unspecified effects of external causes.
79. **Non-Covered Services** - those services excluded from coverage pursuant to this EOC.
80. **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.
81. **Oral Chemotherapy** - Coverage for orally administered chemotherapy for the treatment of cancer. Prominence shall not (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph 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.
82. **Orthotic** - customized devices to support or supplement weakened, or abnormal joints or limbs as defined by Medicare DME guidelines.
83. **Out-of-Network** - Providers that do not have a network agreement with Prominence, or the services provided by such Providers. Out-of-Network Providers are also referred to as non-participating Providers. Out-of-Network Providers are prohibited from collecting an amount for Medically Necessary Emergency Services that exceeds the In-Network Copayment, Coinsurance or Deductible required by this EOC. Out-of-Network Providers who provide services at In-Network facilities in non-Emergency situations are prohibited from collecting an amount for Medically Necessary services that exceeds the In-Network Copayment, Coinsurance or Deductible required by this EOC, unless proper advance notice is provided, and consent is given by the Member.

84. **Out-of-Pocket Maximum** - the combined total expense paid by a Member in Coinsurance, Copayments and Deductible for all Covered Services in a Calendar Year. The Out-of-Pocket Maximum does not include:
    a. Expenses for Covered Services in excess of the Allowed Amount;
    b. Expenses for which no benefits are payable by the Plan; and
    c. Expenses which become the Member's responsibility for failure to comply with the Utilization Management Program or Prior Authorization requirements.
85. **Palliative Dental 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.
86. **Plan** - the contract between You and Prominence consisting of this EOC, the applicable Schedule of Benefits, any applicable riders, Your enrollment form and identification card, any amendments thereto and all other applicable provisions of the laws of the State of Nevada.
87. **Plan Dentist** - a Dentist who has an independent contractor agreement with Prominence to provide Covered Services to Members.
88. **Pneumatic Compression Stockings** - the use of air to create compression.
89. **Premium** - the periodic payment, usually monthly, made to Prominence by You, or on Your behalf, that entitles You to the benefits outlined in this EOC.
90. **Preventive Services** - Preventive Services including periodic physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing, vision, immunizations, health education, intervention services and HIV testing), and additional preventive care for women as provided in the guidelines supported by the U.S. Preventive Services Task Force. This list is not exhaustive. This benefit includes all Preventive Services required by federal and state law - see the Preventive Health Guidelines at doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/.
91. **Primary Care Provider (PCP)** - a General Family Practitioner, Internist or Pediatrician or a mid-level licensed Practitioner such as an Advanced Practical Nurse (APN), Nurse Practitioner (NP) or Physician Assistant (PA) who is chosen by You from the Prominence Directory. Each Member is encouraged to choose a Primary Care Provider. A pediatrician may be designated as the Primary Care Provider for children. For a list of the participating Primary Care Providers, please call Prominence Customer Service at (800)863-7515.
92. **Prior Authorization** - the process in which a Provider must justify the need for delivering a Covered Service or medication to a Member and obtain approval from Prominence 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, or to confirm if Prior Authorization has been obtained, visit Your Member Portal at ProminenceMember.com or call Prominence Customer Services at (800)863-7515. A Member does not need Prior Authorization from the Medical Plan or from any other person (including a Primary Care Provider) to obtain access to obstetrical or gynecological care from a health care professional 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, following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Prominence Customer Service at (800)863-7515, or ProminenceHealthPlan.com.

93. **Prior Deductible Credit** - when Members change to a Prominence Plan 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 Prominence Coverage. Members must request prior deductible credit and submit written notification of such charges to Prominence Customer Service no later than 180 days following the employer's effective date with Prominence.
94. **Professional Services** - those Covered Services, except as excluded or limited in this EOC, performed by Providers which are Medically Necessary and generally recognized as appropriate care within the Service Area and in accordance with Prominence policies and procedures.
95. **Prominence** - Prominence Preferred Health Insurance Company, Inc.
96. **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.
97. **Provider** - A Physician, Professional, organization or association of physicians, Hospital, skilled nursing facility, any organization licensed by a state to render home health services, or any other licensed health care institution or health care professional.
98. **Provider Directory** - a list of Providers which have a contractual relationship with Prominence and that provide Medically Necessary Covered Services to all Members. The Directory contains information about how to contact Providers and their locations but also other helpful information such as language, board certification, qualifications and whether they are accepting new patients. The Provider Directory can be found at ProminenceHealthPlan.com. Additions and changes are continuously made to the Provider Directory; therefore, to confirm a Provider's participation with Prominence or to inquire about further details about a Provider, such as medical school and residency, contact Prominence Customer Service at (800)863-7515 prior to receiving services. The Provider Directory does not imply an employer/employee relationship between Prominence and Providers.
99. **Qualifying Coverage** - any health insurance plan that is considered minimum essential coverage under the Affordable Care Act.
100. **Qualifying Life Event** - An event that changes Your family or health insurance situation and qualifies you for a Special Enrollment Period.
101. **Refraction** - the act of determining the nature and degree of the refractive errors in the eye and correction of the same by lenses.
102. **Rehabilitative Therapy** - physical, speech, occupational, cardiac, and pulmonary/respiratory therapy.
103. **Rescission** - the revocation or cancellation of this Plan with retroactive effect. See Part IX. Termination of Coverage for more details regarding Rescission.
104. **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.
105. **Respite Care** - the short-term, temporary relief to those who are caring for family Members.
106. **Retirees** - One who has retired from active work.
107. **Self-injectables** - Many medications that can be given by the sub-cutaneous or intra-muscular route (excluding insulin) are considered 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 require a specialized setting and/or extensive medical surveillance.
108. **Service Area** - the State of Nevada.

109. **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 EOC.
110. **Skilled Nursing Care** - services that can only be performed by, or under the supervision of, licensed nursing personnel.
111. **Skilled Nursing Facility (SNF)** - a facility which is licensed by the State of Nevada 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.
112. **Sound Natural Teeth** - teeth which are:
    a. Whole or properly restored;
    b. Without impairment or periodontal disease; and
    c. Not in need of the treatment provided for reasons other than Dental Injury.
113. **Specialty Drugs** - includes self-injectables and medications given by self-injection or other routes of administration. Specialty Drugs require the coinsurance listed on Your Schedule of Benefits. Self-Injectables can include combination therapy kits, which can be obtained from an outpatient pharmacy, and can be self-administered. Insulin is not considered a Specialty Drug. Our list of covered Specialty Drugs can be found at ProminenceHealthPlan.com. Contact Prominence Customer Service at (800)863-7515 for more information.
114. **Specialty Pharmacy** - Some Specialty Drugs require the Member to obtain the drug through the Prominence's Specialty Drug Provider. Some Specialty Drugs will be limited to 30-day supplies. Contact Prominence Customer Service at (800)863-7515 for more information.
115. **Specialist** - a physician other than a Primary Care Provider who is listed in the current Provider Directory.
116. **Subscriber** - a person who meets all eligibility requirements of this EOC, whose completed enrollment form has been accepted by Prominence and who has paid, or has had paid on his or her behalf, all applicable premiums. The Subscriber is the person to whom this EOC is issued.
117. **Schedule of Benefits** - the summary of Covered Services, benefit limitations, and Copayments, Coinsurance and Deductibles (if applicable) that are provided to the Group.
118. **Telehealth or Telemedicine** - the remote delivery of healthcare services, such as health assessments or consultations, over the telecommunications infrastructure. It allows Providers to evaluate, diagnose and treat patients using common technology, such as video conferencing and smartphones, without the need for an in-person visit. Telehealth does not include communication that is over facsimile, text or electronic mail. The Provider must hold a valid license or certificate to practice his or her profession in the State in which the patient is located at the time the service is offered.
119. **Total Parenteral Nutrition (TPN)** - the delivery of nutrients through an intravenous line directly into the blood stream.
120. **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.
121. **Urgent Care** - 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.
122. **Usual, Customary and Reasonable (UCR)** - the maximum amount Prominence determines to be eligible for consideration as payment for a particular service, supply or procedure based on geographic area and a comparable condition in nature and severity. For Out-of-Network services, the UCR will be the lesser of the billed charge, the amount We would have considered for payment

if the same service, supply or procedure were performed or provided by an In-Network Provider, or the Medicare reimbursement rate.

123. **Waiting Period** - the time a Member must continuously work for the Group before the Member is eligible for coverage and must be not more than 90 calendar days from the date the waiting period started.
124. **Virtual Visit –** An Urgent Care Telehealth visit delivered via the Member's audio and video enabled device. Use of Prominence's preferred Virtual Visit Provider for Urgent Care services may result in a lower Copayment or no Copayment than if you received that service in person.
125. **We or Us or Our** - refers to Prominence Preferred Health Insurance Company, Inc.
126. **Workers Compensation** - a program of insurance or other coverage plan that covers any Injury or Illnesses arising out of or in the course of employment for pay or profit.
127. **You or Your** - refers to You, Subscriber/Member, and Your eligible enrolled Dependents (Members).

Part II. Advance Directives: Making Your Healthcare Wishes Known

Prominence is required by law to inform You 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. If You can speak for Yourself, 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 Providers from having to guess 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 may find information on Advance Directives at the Nevada Secretary of State website at nvsos.gov/sos/online-services/nevada-lockbox/about-advance-directive-registry or request a form from Your Primary Care Provider. Alternatively, You may wish to speak with Your attorney.

You should provide copies of Your completed directive to:

1. Your Primary Care Provider or other applicable 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 In-Network 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 nevadapolst.org.

Part III. 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 evaluation, planning and coordination of healthcare services for a culturally diverse population. The Comprehensive Utilization Management program 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) retrospective review, care coordination and case management. The Utilization Management staff works under the direct supervision of the Medical Director. Utilization Management review decisions are based only on appropriateness of care, services requested and existence of benefit coverage. Prominence does not incentivize 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 Authorization.

Prior Authorization is the standard process of receiving approval for certain procedures and medical services to ensure that the requested medical care is appropriate and necessary. Prior Authorization review includes eligibility verification, benefit interpretation and administration and Medical Necessity review of both in-patient and out-patient services. Requests for services requiring Prior Authorization are reviewed and determinations made by appropriately licensed Utilization Management personnel. Medical Necessity is determined by the Medical Director. For a complete list of Prior Authorization requirements, please visit Your Member Portal at ProminenceMember.com.

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, 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.

Care Coordination is a collaborative process that 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 for 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.

The Utilization Management team reviews and evaluates 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 with evidence of proven effectiveness to improve the healthcare of Members.

Complex Care Coordination/Case Management is offered by Prominence at Prominence's discretion. Care Coordination/Case Management 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. This specialized service is provided by Registered Nurses.

Contacting Utilization Management: If You have any questions regarding the Utilization Management program or wish to make a referral to Care Coordination/Case Management, please call Prominence Customer Service at (800)863-7515, Monday- Friday, excluding holidays.

2. **CARE COORDINATION SERVICES**

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 also 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 Provider and helping them select an Adult Primary Care Provider.

3. **QUALITY IMPROVEMENT PROGRAM**

Prominence Quality Improvement (QI) Program is designed to assess and improve the quality of care and service delivered to 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 Members through systematic identification and review and evaluation of processes to achieve improvement. An appropriate balance between quality and quantity of healthcare 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 Prominence Organizational Structure and the Quality Improvement Committee and subcommittee structures promote appropriate system development and implementation to meet the requirements of Members, employers, employees and the Provider network.

Additional information regarding the Utilization Management and/or the Quality Improvement programs is available by calling Prominence 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 Providers and employees who make utilization management decisions, affirming the following:

a. Utilization Management (UM) decision-making is based only on appropriateness of care and services and existence of coverage.
b. The organization does not specifically reward Providers or other individuals for issuing denials of coverage or service care.
c. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. Incentives, including compensation, for any person are not based on the quantity or type of denial decisions rendered.

Part IV. 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.
    b. To be eligible for retiree medical benefits You must:
        i. Be an active Member entitled to benefits under this EOC 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 are eligible for Medicare Parts 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 change a coverage election if one of the following qualifying life events has occurred 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. Judgment decree or order requiring coverage; and
        xiii. Change in residence

        An Enrollment form must be completed and received by Prominence within 31 days of the qualifying event.
    d. If an employee refuses coverage at the time of enrollment because the employee had other Qualifying Coverage, the employee 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.

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

2. **Eligible Dependents**

Please contact your employer to determine who in your family may be eligible for coverage under this plan. If your employer chooses to limit coverage of dependents, any provisions in this EOC that discusses eligibility and coverage of dependents is limited to those categories of dependents (if any) that are eligible for coverage, except for eligible children who are always covered within the first 31 days following birth, adoption, or placement for adoption.

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 Group for support and maintenance. This condition must have occurred before the child reaches age 26. Proof of this incapacity must be furnished to Prominence within 31 days after such Dependent attains age 26 and then once a year beginning two years after the Dependent has reached the age of 26. Prominence will require a completed Dependent Disability Verification form, provided by Prominence 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, stepchildren 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 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.

To be eligible to enroll because of the above Qualifying Coverage events, Prominence must receive an application for enrollment and, within 31 days of the date of the Qualifying Coverage event. Once Prominence receives proof of previous Qualifying 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 day 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 must be completed and received by Prominence within 31 days of the event. Coverage is provided without premium for 31 days from birth. Certification by the adoption or placement agency will be required.
f. Marriage, remarriage and/or newly acquired Dependents (e.g., stepchildren) will be covered only if an enrollment form is completed and received within 31 days from the date of marriage.
g. 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 Prominence within 31 days of receipt of the request. Failure to furnish the requested documents will result in ineligibility.
h. 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.
i. A child born to a surrogate is eligible for coverage in the same manner that a natural child described in paragraph (c) above is covered if the intended parent is a Member. If the intended parent is not a Member, then the child born to a surrogate is not eligible for coverage, even if the surrogate is a Member and the child is not eligible for coverage during the first 31 days of life, nor is the child eligible for coverage as a dependent of the Member.

3. **Enrollment**

No person meeting Subscriber or Dependent eligibility requirements will be refused enrollment or re-enrollment by Prominence because of health condition, age, or need for health services. However, if an employer cannot meet the minimum employer contribution or employee participation requirements established by Prominence, coverage may be denied for all employees of that employer, unless the employer applies for coverage between November 15 and December 15.

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.
b. **Group Open Enrollment**: Those periods of time established by the Group and Prominence during which eligible persons who have not previously enrolled with Prominence may do so. The enrollment period shall be held for at least 15 days once every 12 months.

c. **Notice of Ineligibility**: It is Your responsibility to notify Prominence 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 Prominence receives a completed enrollment form, and the appropriate Premium arrangements are made, coverage under this EOC 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 Prominence.
b. **Newly Eligible Employees**: Coverage will become effective after completion of the Group's agreed upon Waiting Period.
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, is received within 31 days from the date of the event. Newly eligible Dependents not added within 31 days of the effective date of coverage as noted in a. and b. above or not added within 31 days of a qualifying event, may not be added until the next Group Open Enrollment Period.

Prominence will provide You with an electronic copy of the EOC and other Member materials upon enrollment. A paper copy of the EOC can be requested at any time by contacting Prominence Customer Service at (800)863-7515.

Part V. Preferred Provider and Out-Of-Network Options

Prominence plans that allow access to its Preferred Provider Network (PPO) and/or national network option allow You to access Medically Necessary Covered Services without receiving a referral from Your Primary Care Provider (PCP). You may seek care directly from any Provider on the PPO and/or national Network. After annual Deductibles are met, You will be responsible for any applicable Coinsurance and Copayments. You are eligible to receive the following medical care and services of Providers, including medical, surgical, diagnostic, therapeutic and Preventive Services which are provided by an In-Network Provider. Copayments required for Medically Necessary Covered Services must be made to the Provider at the time services are received. Refer to the Schedule of Benefits for Your financial obligation.

After annual Deductibles are met, You will be financially responsible for any applicable Coinsurance and Copayments and any charges more than the Allowed Amount. Claims from a Non-PPO Provider must be submitted to Prominence. Non-PPO Providers may require You to pay at the time service is received. All services, except Medically Necessary Emergency Services, received from an Out-of-Network Provider require Prior Authorization from Prominence.

If a PPO or Non-PPO Provider refers You for additional services, including but not limited to diagnostic testing, surgical services, rehabilitative services, Hospital services, or medical equipment, these services must be deemed Medically Necessary by the Prominence Utilization Management Department. Please refer to Your Schedule of Benefits for restrictions on these ancillary services, as benefits may be substantially reduced over those offered by the managed care/HMO portion of Your plan. The following services are not covered under the Out-of-Network tier: organ transplants and organ transplant medications.

Prior Authorization is required for ALL inpatient and outpatient admissions and select other services. Please consult Prominence Customer Service at (800)863-7515 for assistance in determining Prior Authorization requirements. Failure to obtain Prior Authorization will result in a financial Penalty. This Penalty will not apply towards Your annual Deductible or Out-of-Pocket Maximum. Emergency inpatient admissions do not require Prior Authorization and are not subject to a financial penalty; however, notification is required. In the case of an Emergency resulting in a Hospital admission, it is the Member's responsibility to ensure that Prominence is notified immediately, the next business day or as soon as is reasonably possible.

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

Part VI. Services and Benefits

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

1. **Allergy Care**
    a. Coverage is provided for allergy testing and evaluation.
    b. Coverage is provided for the preparation of allergy serum and shots.
    c. Pediatric and adolescent nebulizers are covered for home and school.

2. **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.

3. **Ambulance Services**

    Non-Emergency
    a. Ground ambulance services: Medically Necessary non-Emergency ground ambulance services to transport You from one facility to another facility within the Service Area are covered if arranged in advance by an In-Network Provider and Prior Authorization is provided by Prominence.
    b. Air ambulance services: Medically Necessary non-Emergency air ambulance services to transport You from one facility to another facility are covered within the Service Area only when transport by ground ambulance or other means would endanger Your life or cause permanent damage to Your health, when arranged in advance by an In-Network Provider and Prior Authorization is provided by Prominence.
    c. $25,000 per trip maximum coverage limitation applies.

    Emergency
    d. Ground ambulance services: Medically Necessary ambulance services provided when the ambulance is ordered for an Emergency that could jeopardize Your health.
    e. Ambulance service will be covered when ordered by an employer, school, or public safety official, or when You are not able 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.
    f. 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.
    g. $25,000 per trip maximum coverage limitation applies.

4. **Bariatric Surgery**
    a. Bariatric Restrictive Services are covered when all the following have been determined and are limited to one procedure per lifetime:
        i. The Member must have either:
            1. BMI ≥ 40 kg/m2 without co-morbidities; or

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)
    (a) High risk diseases are chronic coronary disease, atherosclerosis, Type 2 diabetes, or sleep apnea.
    (b) Other obesity-associated diseases include osteoarthritis, gallstones, stress incontinence and gynecologic abnormalities.
    (c) Cardiovascular risk factors included, but not limited to, history of cigarette smoking, hypertension, high LDL cholesterol serum levels, low HDL cholesterol serum levels, impaired fasting glucose, and family history of premature CHD.

ii. Member must be at least 18 years of age;
iii. 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 included nutritional counseling, increased physical activity, behavioral therapy and pharmacotherapy, where appropriate.
    1. The less invasive therapy must have been in place for more than a continuous six-month period.
    2. Failure of less invasive methods is determined by the Plan Medical Director and his/her designee.
iv. Member has been obese for at least five years;
v. If Member is diabetic, disease is controlled;
vi. Member must have the capacity to be compliant with post-surgical treatment or follow-up requirements, which includes a psychiatric or behavioral evaluation;
vii. Procedure must be performed at an In-Network facility unless pre-approved by Prominence to be performed at an Out-of-Network Facility/Provider; and
viii. Member must be tobacco free for (8) eight weeks prior to surgery.

5. **Blood Disease Services**
Coverage is provided for Medically Necessary Covered Services for the non-experimental treatment of sickle cell disease and its variants and hemophilia including, but not limited to, blood products/factor.

6. **Clinical Trial or Study**
The routine medical treatment costs, including all items and services that are otherwise generally available to Our Members, received as part of a clinical trial or study, may be covered. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat disease.

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 Prominence. Investigational medications are not covered.

a. Clinical trial or study must be:
    i. Approved by an agency of the National Institute of Health as set forth in applicable law;
    ii. Approved by a cooperative group, a Network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health;

iii. FDA-approved as an application for a new investigational drug;
iv. Approved by the United States Department of Veterans Affairs; or
v. Approved by the United States Department of Defense.

b. The medical treatment is limited to:
i. Coverage for any drug or device that is FDA-Approved for sale without regard to whether the approved drug or device has been approved for use in Your medical treatment;
ii. The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study, to the extent that such health care services would otherwise be Covered Services;
iii. The cost of any routine health care services that would otherwise be Covered Services for Your participation in a Phase I clinical trial;
iv. The initial consultation to determine whether You are eligible to participate in the clinical trial or study;
v. Health care services required for the clinically appropriate monitoring of You during a Phase II, Phase III, or Phase IV clinical trial or study; or
vi. The costs of drugs available in the Prominence Formulary used to treat the side-effects of a clinical trial.

The following clinical trial services are excluded:

a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical, or medical industry is excluded;
b. Coverage for a drug or device described above that is paid for by the manufacturer, distributor, or Provider of the drug or device is excluded;
c. Health care services that are specifically excluded from coverage in this EOC, regardless of whether such services are provided under the clinical trial or study are excluded;
d. Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to participants in the trial or study are excluded;
e. Extraneous Expenses related to You in the clinical trial or study including but not limited to travel, housing, and other Expenses that You may incur are excluded;
f. Any Expenses incurred by a person who accompanies You during the clinical trial or study are excluded;
g. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of You is excluded;
h. Any costs for the management of research relating to the clinical trial or study are excluded; and
i. Any costs for drugs not available through the Prominence Formulary are excluded.

7. **Cochlear Implants & 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. This cochlear implant benefit is limited to one per lifetime. Cochlear device implantation requires Prior Authorization from Prominence.
b. While not included in all Plans, hearing aids may be covered for Members with a medically diagnosed hearing loss significantly impacting their daily communication, such as difficulty understanding speech in noisy environments, following conversations, or needing frequent repetition. Significant hearing improvement by a Provider's assessment is required.

Additionally, hearing aids must be professionally fitted by an In-Network audiologist or ENT Provider. Over-the-Counter hearing aids are excluded. For coverage benefits and limitations, please refer to Your SOB.

8. **Contraception and Sterilization**
   a. A 12-month supply per prescription of FDA approved oral contraceptive pharmaceuticals, Intrauterine device (IUD), Diaphragm and NuvaRing, including insertion and removal of a prescribed device for contraception, are covered. Please refer to the Formulary for a complete list of covered pharmaceuticals and devices, available at ProminenceHealthPlan.com.
   b. FDA approved contraception and contraceptive education and counseling are covered.
   c. Management of side effects relating to contraception are covered.
   d. FDA approved sterilization procedures, including services, treatment, and procedures to induce voluntary elective sterilization are covered.
   e. FDA approved hormone replacement therapy is covered.
   f. Long-acting reversible contraception injected or inserted at a hospital immediately after giving birth is covered.

9. **Dental Care Services**

Dental 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 and biting. Treatment and repair must begin within six (6) months of the date of a documented Injury and requires Prior Authorization from Prominence.
   b. Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and/or floor of the mouth.
   c. Use of an outpatient or inpatient facility for dental procedures/services may be covered using the following criteria and if Prior Authorization is provided by Prominence:
      i. Coverage is for dependent children less than 18 years of age only.
      ii. The Member must have a diagnosed medical or behavioral condition, which requires outpatient hospitalization or general anesthesia when dental care is provided.
      iii. Services must be provided by a designated contracted facility and anesthesiologist.
      iv. Services rendered by a dentist are not a Covered Service; and
   d. Dental examinations, dental implants, bridges, dental prescriptions, orthodontia and any other dental products or services are not covered except when related to Accidental Dental Injury to sound natural teeth.
   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 Medically Necessary criteria for orthognathic surgery is met. Prior Authorization is required, and coverage is limited.
      i. The orthognathic surgical benefit is limited to one procedure per Calendar Year.
   f. Medically Necessary appliance therapy that does not permanently alter tooth position, jaw position or bite relationship is covered if Prior Authorization is received from Prominence. The benefit for appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, and repair of the appliance. Dental orthotics or appliances including, but not limited to, oral appliances and night guards, are limited to one per Calendar Year. Note: Night guard appliances are not subject to the Temporomandibular Joint Disorder (TMJ) benefit limits.

g. Temporomandibular Joint Disorder (TMJ): Medically Necessary services for any jaw joint problem, including TMJ disorder, craniomandibular disorder, head and neck neuromuscular disorder, or other conditions of the joint linking the jawbone and skull include only medical services and require Prior Authorization from Prominence. 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 or surgery are covered if Medically Necessary. Services must be provided by an In-Network Provider.
    ii. The following are not Covered Services for TMJ:
        1. CT Scans or magnetic resonance imaging (MRI) except in conjunction with surgical management;
        2. Electronic diagnostic modalities;
        3. Occlusal analysis;
        4. Any procedure not specifically listed as a Covered Service.
        5. Must comply with Medical Necessity criteria.
h. Failure of the Member to comply with the requirements of the Utilization Management Department will result in a reduction of benefits.

10. **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:

a. Biopsy or clinical appearance suggests or is indicative of pre-malignancy or malignancy;
b. Due to its anatomic location, the lesion has been subject to recurrent trauma;
c. 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);
d. Skin lesions are causing symptoms (e.g., bleeding, burning, itching or irritation);
e. The lesion has evidence of inflammation (e.g., edema, erythema, or purulence);
f. The lesion is infectious (e.g., warts);
g. The lesion restricts vision or obstructs a body orifice; or
h. In the absence of any of the above indications, removal of benign skin lesions is considered Cosmetic.

11. **Diabetic Supplies and Services**

Coverage is provided for insulin and insulin syringes, diabetic blood test strips and lancets. Each item requires a separate prescription. A Copayment applies per 200 strips. This benefit must be coordinated by an In-Network Provider and obtained from an In-Network Pharmacy. Services also include:

a. Training and education;
b. Routine foot care;
c. Diabetic custom-made shoes and/or foot orthotics for diabetes are covered at two pair per Calendar Year and must be prescribed by a Provider; and
d. Routine retinal examination which does not include the determination of Refraction.

12. **Durable Medical Equipment (DME)**

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, must be coordinated by an In- Network Provider and requires Prior Authorization from Prominence.
b. DME must meet Medicare standards and must be provided because 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 that 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.
e. 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.

13. **Eating Disorders**
    a. Partial hospitalization, including residential treatment, for the treatment of Anorexia Nervosa, Bulimia Nervosa or Eating Disorders is covered.
        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. Coverage is provided for up to 25 visits per Calendar Year for Medically Necessary medical nutrition therapy/nutritional counseling, with a Provider for the following conditions: Diabetes, Obesity (BMI greater than 40 or BMI less than 35 with co-morbidities), Renal failure, GI Disorders and Eating Disorders.

14. **Emergency Care Services**

Coverage is provided for Medically Necessary Emergency Services, including medical and surgical care at both In and Out-of-Network Providers. In the Prominence Service Area, coverage for Emergency Services is available 24 hours per day, seven days per week, at In-Network Providers. Under the Affordable Care Act and the No Surprises Act, Prominence is not permitted to apply higher copayments or coinsurance for Out-of-Network Emergency room services or require approval before seeking Emergency room services from a Provider or hospital In or Out-of-Network.

Get help as quickly as possible. Call 911 for help or go to the nearest emergency room or hospital.

a. Emergency Services are provided:
    i. Without regard to whether the Provider of the services is In-Network;
    ii. 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
    iii. 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.
b. If a Member receives Emergency Services from an Out-of-Network Provider, the Provider is prohibited from collecting an amount for Medically Necessary services that exceeds the In-Network Copayment, Coinsurance or Deductible required by this EOC.
c. Emergency Care Services do not include instances when You are seen in an Emergency room for a condition that was not Medically Necessary and that Prominence determines did not require Emergency Services, or follow-up care obtained through an Emergency room. Services received in an Emergency Room that do not require Emergency Services and follow-up care obtained in an Emergency Room or Urgent Care are not covered benefits. When You are seen in an Emergency room for a condition that was not Medically Necessary and that Prominence

determines did not require Emergency Services, or fail to follow the proper procedures listed below, You will be held financially responsible for all charges related to the visit. In addition, Prominence will not pay benefits for Emergency 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.

d. In case of an Emergency resulting in a Hospital admission, it is the Member's responsibility to ensure that Prominence is notified within 48 hours, the next business day after the admission, or as soon as reasonably possible.
e. In case of out-of-country Emergency services, Members must pay and submit a receipt, translated into English, as well as any supporting medical records translated into English, for reimbursement.

15. **Gender Affirming Treatment**

Coverage for the medically necessary treatment of conditions related to gender dysphoria and gender incongruence includes psychosocial and surgical interventions. Gender affirming surgery is a treatment option for gender dysphoria, a condition in which a person experiences persistent incongruence between gender identity and sexual anatomy at birth. Gender affirming surgery is not an isolated intervention; it is part of a complex process involving multiple medical, psychiatric, and psychologic, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes. Prominence has adopted the most recent Standards of Care published by the World Professional Association for Transgender Health (WPATH) for determining medical necessity. The following services are covered when Medically Necessary, coordinated by an In- Network Provider, and a Prior Authorization is provided by Prominence.

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; 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:

a. Breast cancer screening may be Medically Necessary for female to male trans-identified persons who have not undergone a mastectomy;
b. Prostate cancer screening may be Medically Necessary for male to female trans-identified persons who have retained their prostate.

Coverage for the medically necessary treatment of conditions related to gender dysphoria and gender incongruence includes psychosocial and surgical interventions. Gender affirming surgery is a treatment option for gender dysphoria, a condition in which a person experiences persistent incongruence between gender identity and sexual anatomy at birth. Gender affirming surgery is not an isolated intervention; it is part of a complex process involving multiple medical, psychiatric, and psychologic, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes. Prominence has adopted the most recent Standards of Care published by the World Professional Association for Transgender Health (WPATH) for determining medical necessity.

16. **Genetic, Biomarker and Breast Cancer (BRCA) Testing**

Covered Services include Medically Necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Biomarker testing may be called a companion diagnostic test when it is paired with a specific cancer treatment. Biomarker testing is approved for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer in certain circumstances. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Policy. Testing must be conducted by an in-network provider for whom the testing is within his or her scope of practice, training, and experience. The following services require Prior Authorization from Prominence:

a. Coverage is provided for Genetic Testing and Breast Cancer (BRCA) Testing as prescribed and must be coordinated by an In-Network 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; or
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) and is subject to Prior Authorization.
e. Additional genetic testing will be covered as required by Federal or state mandates.

17. **Home Health Services**

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. Such care will not be available if it is substantially or primarily for the Member's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or appropriate therapist. Home Health Services require Prior Authorization from Prominence. Short-term rehabilitation limitations apply to Home Health Services.

18. **Hospice Care**

A Member is considered terminally ill if an In-Network 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. Outpatient counseling of the Member and his or her immediate family (limited to five (5) therapy sessions for all family Members if they are not otherwise eligible for mental health benefits under their specific Plan). 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. Respite care is limited to 5 inpatient days or 5 outpatient visits, combined, every 90 days.

19. **Hospital Services**

a. Inpatient Services: Coverage is provided for the following Medically Necessary Covered Services when Prior Authorization is provided by Prominence. It is the Member's responsibility to notify Prominence of an inpatient hospital admission within 48 hours or the next business day; failure to notify Prominence will result in a financial penalty.
    i. Semi-private room and board;
    ii. Inpatient In-Network 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 which 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; and
x. Cardiac Rehabilitation Program Phase I.

b. Outpatient, Ambulatory and Surgical Services: Coverage is provided for the following Medically Necessary Covered Services when Prior Authorization is provided by Prominence.
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 Prominence Medical Director is subject to significant clinical improvement;
iii. Outpatient surgery and diagnostic procedures;
iv. Cardiac Rehabilitation Program Phase II; and
v. When Your outpatient status changes to inpatient, You will be responsible for an inpatient Copayment and/or Deductible/Coinsurance.

c. Inpatient Skilled Nursing/Acute Rehabilitation Facility: Coverage is provided for Skilled Nursing/ Acute Rehabilitation Facility services when Medically Necessary and Prior Authorization is provided by Prominence.
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 Provider, or after the maximum benefit period is reached, You will be financially responsible for all associated costs for the services.
iii. Skilled nursing is covered up to 100 days per Calendar Year.
iv. Acute rehabilitation is covered up to 60 visits per condition per Calendar Year.

Observation lasting greater than 24 hours requires Prior Authorization from Prominence.

20. **Kidney Dialysis Services**
    a. Coverage is provided for Medically Necessary kidney dialysis services and related therapeutic services and supplies, to the extent not covered by the Medicare Program. These services must be coordinated by an In-Network Provider.

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 Plan Provider.

22. **Maternity and Newborn Care**
    a. 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. Prior Authorization is required for any days of confinement that exceed the above time periods. 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; and
iv. Use of Newborn nursery and related facilities.

Subject to the exclusions regarding infertility testing and services, the above maternity services are covered for a Member who is a surrogate or gestational carrier.

23. **Mental Health Services and Substance Abuse Benefit**

Prominence will provide mental health and substance abuse benefits to covered Members subject to all conditions, limitations, and exclusions listed in the EOC document. Refer to the Schedule of Benefits for the corresponding deductible, coinsurance and/or 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 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 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 Schedule of Benefits.
   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.
   vi. **Medication-assisted Treatment for Opioid Use Disorder:** Coverage is provided for FDA-approved Medically Necessary medication-assisted prevention and treatment for opioid use disorder prescribed by an in-network provider or pharmacist/pharmacy.
b. Mental Health Disorders Benefit Description
   i. **General Mental Health**: Coverage is provided for outpatient general mental health services when coordinated by In-Network 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 including a family therapist or social worker.
   ii. **Severe Mental Illness**: Coverage is provided for Medically Necessary severe mental Illness services when coordinated by In-Network Providers. Treatment is limited to the following conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders and/or obsessive-compulsive disorder.

1. Severe Mental Illness benefits include Inpatient treatment, Outpatient Office Visits and Day Treatment Programs.
2. 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 Schedule of Benefits.

Mental health, alcohol & chemical dependency services, including inpatient, residential, partial hospitalization, acute detox, acute rehab, intensive outpatient programs, electroconvulsive therapy, applied behavior analysis, neuropsychological testing and psychological testing require Prior Authorization from Prominence.

24. **Nutritional Supplements, Enteral Therapy and Parenteral Nutrition**
    a. Coverage is provided for enteral formulas and special food products for use at home when prescribed or ordered by an In-Network Provider as Medically Necessary for 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.
    b. 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 Provider for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.
    c. 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.
    d. 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 Necessary upon review every 21 days for a maximum of 120 days.
    e. The use of nutritional supplements, enteral formulas, parenteral nutrition, and other special food products require Prior Authorization from Prominence.

25. **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 require Prior Authorization from the Prominence Medical Director.

    a. Transplants to a Member are limited to heart, kidney, cornea, pancreas, liver, lung, tendons, sclera, and allogenic and autologous bone marrow only.
    b. Coverage is provided for the Medically 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. Clinical trial medications and devices that have not been approved by the FDA are not covered.
    d. Transplants utilizing any animal organs are not a Covered Service.
    e. Procedures must be performed at a Prominence transplant network facility.
    f. Combined expenses incurred for all human body organ transplant services, including follow-up care, Home Healthcare, immunosuppressive medications, and donor expenses for non-experimental human-to-human procedures are covered.

g. FDA-approved immunosuppressive post-transplant medications may be covered under this EOC or pharmacy benefit depending on the prescription drug dispensed.

26. **Plastic and Reconstructive Surgery**
When Medically Necessary, the following Covered Services require Prior Authorization from Prominence:
    a. Reconstructive surgery incidental to or following surgery resulting from acute trauma, infection, or other diseases of the involved body part;
    b. Surgery for a Congenital disease or anomaly that 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; and
    d. Breast reductions and the removal of ruptured breast implants (excluding replacements unless related to a prior mastectomy) when Medically Necessary.

27. **Prescription Drug Benefit**
    a. A Member is eligible for prescription drug benefits provided at an In-Network pharmacy or in connection with covered Emergency services while outside of the 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).
    b. Prescription drug benefit definitions:
        i. **Plan Pharmacy**: a pharmacy contracted with Prominence to dispense Prescription Drugs to Members for benefits under the prescription drug benefit. The Plan Pharmacy list is available at ProminenceHealthPlan.com or by contacting the Pharmacy Help Desk at (833)775-MEDS (6337).
        ii. **Out-of-Network Pharmacy**: a pharmacy that is not within Prominence's network.
        iii. **Prescription Drug (or "Prescription")**: drugs or medications which, according to federal law, can only be obtained legally with a written prescription from a licensed Provider; they are 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.
        iv. **Generic Drugs, Preferred Brand Drugs and Non-Preferred Brand Drugs and Specialty Drugs**, require You pay the appropriate copay, deductible and/or coinsurance as listed in the Schedule of Benefits. Member must pay the copayment to the Pharmacy at the time the Prescription is filled. For each prescription or refill, up to a 90-day supply may be dispensed unless limited by the Prominence Formulary. Covered Generic, Preferred Brand Drug Non-Preferred Brand Drug, and Specialty Drugs are listed on Prominence Formulary.
            1. **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.
            2. **Preferred Brand Drug**: a prescription drug patented and given a brand or trade name by the drug manufacturer.
            3. **Non-Preferred Brand Drug**: A Brand Drug that often has a Generic equivalent and is listed on the Formulary.
            4. **Specialty Drug**: A generic or brand drug that is on the Formulary and is high cost and requires special monitoring and handling.

v. **Specialty Pharmacy**: Some Specialty Drugs require the Member to obtain the drug through the Prominence Specialty Drug Provider. Contact the Pharmacy Help Desk at (833)775-MEDS (6337) for more information.

vi. **Formulary**: Prominence's list of covered Prescription Drugs. Prescription drug coverage requires Members to use the Prominence Formulary.

1. This list of medications is created and maintained by the Prominence Pharmacy and Therapeutics Committee, based upon current medical standards of practice. Some medications on the Formulary may require Prior Authorization, Step Therapy, Age Restrictions and/or have a limited benefit. Approved U.S. Food and Drug Administration (FDA) female oral contraceptive generic drugs are listed in the Formulary. If You wish to receive a copy of the Prominence Formulary, please visit ProminenceHealthPlan.com or contact the Pharmacy Help Desk at (833)775-MEDS (6337).
2. 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. Prominence drug evaluations are based on several factors:
   (a) FDA-approved indications
   (b) Efficacy
   (c) Adverse effect profile
   (d) Patient monitoring requirements
   (e) Impact on total healthcare costs
   (f) Comparison to other preferred agents
3. The Pharmacy and Therapeutics Committee, may move a Prescription Drug from a Formulary tier with a lower Member cost to a Formulary tier with a higher Member cost only:
   (a) On January 1;
   (b) On July 1; or
   (c) When Prominence adds a Generic Drug that is approved by the FDA as an alternative to the original prescription drug and the Member cost for that generic prescription drug is equal to or less than the original prescription drug was prior to the addition of the Generic Drug.
4. The Pharmacy and Therapeutics Committee, may, at any time:
   (a) Move a Prescription Drug from a Formulary tier with a higher Member cost to a Formulary tier with a lower Member cost;
   (b) Remove a Prescription Drug from the Formulary; or
   (c) Add a Prescription Drug to the Formulary.

vii. **Covered Contraceptive Pharmaceuticals**: FDA-approved female Oral Contraceptive Generic Drugs and select preventive medications listed on the Prominence Formulary require no Member share of cost when prescribed by Your Primary Care Provider or other In-Network Provider and obtained from a Prominence Plan Pharmacy.

viii. **Maintenance Drugs**: Drugs available in a 90-day supply at retail pharmacies or through mail order. A 90-day supply of a Maintenance drug dispensed at retail or mail order will require the payment of two times the Generic Drug copayment; two times the Preferred Brand Drug copayment; or three times the Non-Preferred Drug copayment, depending on the drugs dispensed. Specialty Drugs are not considered Maintenance drugs; they cannot be purchased with a 90-day supply.

ix. **Diabetic Supplies**: Diabetic blood test strips, syringes and lancets are covered but may require a copayment in accordance with Your preferred drug list. For additional information about Diabetic Supplies, please see the Diabetic Services and Supplies section of this document.

x. **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 Drug. However, if a Generic Drug is available, You will be responsible for the cost difference between the Generic and Brand Drug, in addition to Your Generic copayment.

xi. **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 or more medications before a similar, more expensive, Drug is dispensed. This means that certain drugs will not be covered until other specific prescription drugs are tried first unless Your physician contacts Prominence to obtain a Prior Authorization Step Therapy Exception. Prominence's Step Therapy process is described in its Pharmacy Benefits Guide available online and by request by calling the Pharmacy Help Desk at 833-775-MEDS (6337).

xii. **HIV**: To the extent authorized by federal law, an In-Network pharmacist who meets the requirements prescribed by the Nevada State Board of Pharmacy may 1) order and perform laboratory tests that are necessary for therapy that uses a drug approved by the FDA for preventing the acquisition of human immunodeficiency virus; and 2) prescribe, dispense and administer any FDA approved drug necessary to prevent the acquisition of human immunodeficiency virus.

c. The Prescription Drug Benefit includes coverage for early refills of topical ophthalmic products 21 days for 30-day supply, 42 days for 60-day supply, 63 days for 90-day supply.

d. The Prescription Drug Benefit includes coverage for synchronized medication fills dispensed by a pharmacy.

e. The prescription drug benefit includes coverage for drugs previously approved for coverage by the carrier for a medical condition of a Member if the Member'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 Member; and it is appropriately prescribed and considered safe and effective for treating the medical condition of the Member.

f. **Prescription Drug Benefit Exclusions**:

i. Administration - Any charges for the administration or injection of Prescription Drugs or Injectable insulin and other Injectable Drugs covered by Prominence are excluded.

ii. Complications - Drugs to treat complications resulting from procedures, services, medical treatments, or medications that are not covered by this Policy are excluded.

iii. Compounded Medications - Compounded medications except for compounded medications for palliative care with Prior Authorization are excluded.

iv. 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 are excluded.

v. Dietary Aids and Appetite Suppressants - Dietary or nutritional products, including prescription drugs that are not covered under the pharmacy benefit, prescription, or non-prescription vitamins (except those prescribed pre-natal vitamins listed on the

Prominence Formulary), appetite suppressants, and diet pills used for weight reduction are excluded, except as otherwise permitted in this EOC.

vi. Erectile Dysfunction Drugs - Drugs when used for the treatment of erectile and/or sexual dysfunction are excluded. However, if the same drugs are also FDA approved to treat conditions outside of erectile and/or sexual dysfunction, these drugs may be covered in accordance with the Prominence Formulary.

vii. 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 are excluded, except as otherwise permitted under Federal or State law. However, for drugs that are FDA approved for market in the United States, certain drugs, including drugs used for cancer, may be covered for off label indications if certain circumstances are met.

viii. Fertility Drugs - Drugs/Products used for the treatment of impotence or infertility are excluded, except as otherwise permitted in this EOC and Your Schedule of Benefits.

ix. Medical Cannabis is excluded.

x. Nail Fungal Medications and/or Preparations are excluded.

xi. Non-Covered Drugs - Any prescription drug prescribed in connection with a Non-Covered Service is excluded. This includes any drug not listed on the Formulary.

xii. Non-Approved Drugs - Drugs determined by the Prominence Pharmacy and Therapeutics Committee as ineffective, duplicative, or having preferred formulary alternatives are excluded.

xiii. Non-Network Pharmacy - Drugs dispensed by other than an In-Network Retail Pharmacy, In-Network Mail Order Pharmacy, or In-Network Specialty Pharmacy are excluded except as Medically Necessary for treatment of an Emergency or Urgent Care condition.

xiv. Not Medically Necessary - Drugs that are not Medically Necessary or not required in accordance with accepted standards of medical practice or applicable law are excluded.

xv. Over-the-Counter Drugs - Over-the-counter drugs and other items that do not require a written prescription are excluded (even if ordered by an In-Network Provider).

xvi. Scope of License - Drugs prescribed by a Provider not acting within the scope of his or her license are excluded.

28. **Preventive Services**

The following Preventive Services are covered by Prominence at no cost to the Member if provided by an In-Network Provider:

a. Periodic health assessments, i.e., annual physicals for adults, as recommended by Your Primary Care Provider 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 Primary Care Provider or as per recommendations from the U.S Preventive Services Task Force;

c. Baseline mammography, 3D mammography, diagnostic mammography x-ray, and breast MRI for screening and diagnostic testing and periodic mammography annually for insureds 40 years of age or older; or at an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider based on personal or family medical history or additional factors that may increase the risk of breast cancer.

d. Prostate screening as recommended by Your Primary Care Provider or as per recommendations from the U.S Preventive Services Task Force in accordance with American Cancer Society;
e. Well-child visits and annual physicals as recommended by Your Primary Care Provider 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 Primary Care Provider 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 pair 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 unless age limits are removed by Prominence;
j. Smoking cessation programs consisting not more than two cessation attempts per year and four counseling sessions per year are covered for Members who are 18 years of age or older.
k. Vaccines for human pappillomavirus at such ages as per recommendations from the Advisory Committee on Immunization Practices; and
l. Women's Preventive Services:
    i. FDA-approved contraceptive products;
    ii. Domestic and interpersonal violence screening and counseling;
    iii. Well-woman visits as recommended by Health Resources and Services Administration (HRSA);
    iv. BRCA genetic counseling and testing services;
    v. Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a Provider of health care;
    vi. Prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;
    vii. Human Papillomavirus (HPV) DNA testing, for women 30 or older; Includes deoxyribonucleic acid testing for high-risk strains of HPV every 3 years for women 30 years of age or older;
    viii. Sexually transmitted infections (STI) counseling;
    ix. HIV screening and counseling;
    x. Screening for depression;
    xi. Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization; and
    xii. Breastfeeding support, supplies, and counseling.

    For more information visit the U.S Preventive Services Task Force: hrsa.gov/womens-guidelines.

For a full list of covered Preventive Services, please go to: doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care/.

Some services listed may be billed as diagnostic procedures instead of preventive/screening procedures, which could incur Member cost sharing. Diagnostic procedures are usually conducted when the Member has already been diagnosed with an Illness or disease, or the Member is receiving

follow-up treatment for an existing medical condition. In addition, the Member may incur expenses if additional procedures that are not listed on the "Preventive Services" list are conducted concurrently with the Preventive Service.

Generally, Prominence covers Preventive Services beginning no later than the plan year beginning one year after the service is added to the following lists:

- Services with an A or B Recommendation from the U.S. Preventive Services Task Force;
- Immunization recommended by the Advisory Committee on Immunization Practices of the CDC;
- Preventive Care and Screenings for infants, children and adolescents supported by the Health Resources and Services Administration; and
- Preventive Care and Screenings for women supported by the Health Resources and Services Administration.

29. **Professional Services**
    a. **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 a Provider. Wound therapy, pain management procedures, therapeutic joint injections, implants, and sleep or snoring treatment for central or obstructive apnea, provided in an office setting, or other setting, require Prior Authorization from Prominence.
    b. **Provider Hospital Visits:** Medically Necessary Covered Services for diagnosis, treatment and consultation are provided for inpatient and outpatient Hospital services for which Prior Authorization has been provided by Prominence.
    c. **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.

30. **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.
    b. 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.
    c. Orthotics and artificial aids, such as cardiac pacemakers and artificial heart valves, are a Covered Service when Medically Necessary.
    d. Foot orthotics are limited to one pair per Calendar Year.
    e. The Prosthetic or Orthotic devices are defined by the Medicare DME guidelines.
    f. 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.
        i. Prescription lenses, eyeglasses or contact lenses for treatment of keratoconus are limited to one basic pair per Calendar Year.

31. **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 Provider. Complex Diagnostic Testing and imaging studies require Prior Authorization from Prominence.
b. Coverage is provided for Diagnostic Colonoscopy and Sigmoidoscopy as Medically Necessary.

32. **Spinal Manipulation**
    a. Spinal manipulation covers treatment for 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).

33. **Telehealth**

You may receive services from a Provider who is in a different location using information and audio-visual communication technology. Telemedicine does not include communication through facsimile, text, or email.

Prominence will not prevent the use of Telemedicine in a course of treatment or evaluation. Prominence will not prevent the use of Telemedicine based on where the Provider is located.

A Provider who uses Telemedicine to provide services is responsible for ensuring he or she complies with all federal and state laws, including licensure, at the location in which the patient is located. Prominence will not pay claims for services provided by Providers who are not licensed in the state where the patient is located.

Your cost for services received by using Telemedicine are the same as if the service were received in person. However, Prominence does not control the methods of treatment and business arrangements between third parties. Therefore, You may have to pay both the originating site and the Provider located at the distant site.

Additionally, it is Your responsibility to ensure the Providers You use are In-Network Providers. Failure to use In-Network Providers will result in a higher cost to You.

Use of Prominence's preferred Virtual Visit Provider for Urgent Care services may result in no Copayment or a lower Copayment than if you received that service in person. See your Schedule of Benefits for pricing and restrictions.

34. **Therapies (Physical, Occupational, Speech, Autism, Rehabilitative and Habilitative)**
    a. Speech, physical, developmental, and occupational therapy are provided on a Short-Term outpatient basis and must be coordinated by an In-Network Provider. Outpatient Short Term Rehabilitation Services are limited to treatment of conditions the Prominence 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.
    i. Treatment of autism spectrum disorders, regardless of age, 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:
        1. Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
        2. 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.
    ii. The maximum benefit for the treatment of Autism Spectrum Disorder is up to 1,500 hours per Calendar Year.
e. All rehabilitative and habilitative services require Prior Authorization from Prominence.

35. **Urgent/Ambulatory Care Services**
    a. All benefits included in this EOC 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 should be provided by Your PCP. When You are seen in an Urgent/Ambulatory Care facility for a condition not Medically Necessary and that Prominence 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.

36. **Vision Care Services-for children through the end of the month of the child's 19th birthday**
    a. Coverage is provided for vision examination (refraction), when provided by a duly licensed Vision Care Provider, to determine the presence of vision problems or other abnormalities. Refraction exams are limited to one per Calendar Year for individuals up to the age of 19.
    b. Coverage is provided for prescribed corrective lenses or eyeglass frames as follows:
        i. Frames and/or Prescribed Corrective Lenses; or
            1. This benefit is limited to one pair of basic glasses (Frames and Prescribed Corrective Lenses) per Calendar Year.
        ii. Prescribed Corrective Contact Lenses:
            1. Prescribed corrective contact lenses are limited to six (6) pairs per Calendar Year.
        iii. Vision Care Services are covered to the maximum allowance or billed charges, whichever is less:
            1. upon proof of payment by Member; or
            2. upon receipt of a claim/billing form from Provider.
    c. The vision services described in this section are not available after the end of the month of the Member's 19th birthday.

37. **Women's Health and Cancer Rights Act (WHCRA)**
    As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

a. All stages of reconstruction of the breast on which the mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prosthesis and treatment of physical complications of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;
d. Treatment of physical complications of all stages of mastectomy, including lymphedemas; and
e. Such coverage may be subject to the same annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under this plan.

Part VII. Exclusions, Limitations and Non-Covered Services

Exclusions, limitations, and non-covered services are any service or item not considered Medically Necessary by an In-Network Provider. The final determination of Medical Necessity is the judgment of the Prominence Medical Director. In addition to the Exclusions and Limitations described in this section, this EOC 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 related 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 are excluded, except as otherwise permitted in this EOC.
2. **Chelation treatment** - Chelation Therapy is excluded, 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) erroneous 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 are excluded. 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, wheelchair lifts, four-channel muscle stimulators and any other primarily non-medical equipment are excluded. Special equipment and devices used for sports are excluded.
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 are excluded.
6. **Copies of records** - Charges for copies, presentation and preparation of Your records, charts or x-rays, completion of insurance forms, creation of medical or dental reports and costs to forward or mail any such copies, forms, reports, records, charts, or x-rays are excluded.
7. **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 are excluded. Cosmetic Exclusions include, but are not limited to, the following:
    a. Abdominoplasty is excluded, regardless of Medical Necessity.
    b. Surgery for sagging or extra skin, to include thigh, leg, hip, buttock, arm, forearm, and hand, is excluded, regardless of Medical Necessity.
    c. Face lifts, brow lifts and rhinoplasty are excluded, regardless of Medical Necessity.
    d. Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedure to alter Refraction are excluded.
    e. Any augmentation or reduction procedures or correction of facial or breast asymmetry are excluded. Breast augmentation, lifts or reductions that are not associated with cancer of the breast are excluded, regardless of Medical Necessity. Removal of breast implants or breast reconstruction that is not associated with breast cancer is excluded. Medically Necessary breast reductions and removal of ruptured breast implants (not replacements unless related to a prior mastectomy) are covered when Prior Authorization is provided by Prominence.
    f. Hair removal or treatment of baldness is excluded.
    g. Scar revision therapy and laser services for scars is excluded.

h. Any implant, appliances or devices used to improve the appearance and/or function of a portion of the body is excluded, regardless of Medical Necessity.
i. Earring Injuries and/or earlobe repairs are excluded.
j. All body piercings are excluded.
k. 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 are excluded, regardless of Medical Necessity, except as otherwise permitted in this EOC.
l. 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.

8. **Court ordered services** - Court ordered treatments including, but not limited to, long-term mental health, chemical dependency and psychiatric treatment are excluded. Pretrial or court testimony and/or the preparation of court-related reports are also not covered under this EOC, as well as any care or service while incarcerated.
9. **Cranial helmets** - Cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome.
10. **Dental** - Dental services 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 are excluded under the medical benefit.
    a. Treatment or replacement of any tooth or any supporting tooth structure, alveolar process, or disease of the periodontal or gingival tissue is excluded.
    b. Surgery or splinting to adjust dental occlusion is excluded.
    c. Maxillary or mandibular surgery, except as otherwise permitted in this EOC.
    d. Any irreversible procedure including, but not limited to, orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures is excluded.
11. **Dermatology** - Removal of a benign skin lesion(s) is considered Cosmetic and is excluded except as otherwise specified in this document.
12. **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 and return-to-work evaluations are excluded. Services, treatment and evaluation for learning disabilities and 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 or other governmental agency are excluded.
13. **Double coverage** - Costs 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, are excluded.
14. **Duplicate items** - Duplicate items, services, supplies or equipment to be used outside the home or for work or travel are excluded.
15. **Examinations/immunizations** - Physical examinations or immunizations when required for employment, insurance, licensing, marriage, sports, or travel and physical or work hardening capacity examinations are excluded.
16. **Experimental/investigational** - Any services that in Prominence's sole discretion are determined to be experimental or investigational medical, surgical, or other procedure or treatment, including

prescription medications, unless otherwise directed by State Federal regulations, are excluded. A procedure or treatment is considered experimental:

a. If there is insignificant outcomes data available from controlled clinical trials and from medical literature to show that the procedure or treatment is safe and effective;
b. 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;
c. If it is determined that the procedure or treatment is not generally accepted by the medical community within the State of Nevada or Prominence's Service Area;
d. When a nationally recognized medical society states in writing that the procedure or treatment is experimental;
e. When the written protocols used by a facility studying the procedure or treatment state that it is experimental; or
f. 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 service is to be rendered.

17. **Family planning** - Services and procedures that have a direct and intended purpose for the induction of abortion are excluded. 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 are excluded.
18. **Illegal conduct** - Except as outlined, services provided because of Injuries sustained while in the act of committing a felony offense, while being held by a law enforcement agency, pursued by law enforcement personnel or while incarcerated in prison, jail or juvenile detention centers are excluded. Members will be afforded due process and will not have coverage excluded based on an allegation, or the belief of wrongdoing. This exclusion does not apply in the case of conditions or Injuries arising out of acts of domestic violence. Prominence shall not deny a claim solely because the claim involves an Injury sustained by a Member because of being intoxicated or under the influence of a controlled substance. However, Medical or Hospital services provided because of Injuries sustained while driving under the influence of controlled substances or alcohol, when convicted of a felony, as defined by current State law may be excluded.
19. **Infertility treatment/services** - Embryonic transfer, Gamete intra-fallopian transfer (GIFT), in vitro fertilization and sperm donation (including storage of) or any related diagnostic testing or services for treatment of infertility is excluded. Additional Exclusions include, but are not limited to, the following:
    a. Laboratory studies.
    b. Diagnostic procedures.
    c. Artificial insemination services.
    d. 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 and sperm washing are excluded, except prior to artificial insemination if required.
    e. Home pregnancy or ovulation tests are excluded.
    f. Monitoring of ovarian response to stimulants is excluded.
    g. CT or MRI of sella turcica are excluded.
    h. Sterilization reversal is excluded.
    i. Laparoscopy is excluded.
    j. Ovarian wedge resection is excluded.
    k. Removal of fibroids, uterine septae and polyps is excluded.
    l. Open or laparoscopic resection, fulguration, or removal of endometrial implants is excluded.

m. Surgical lysis of adhesions is excluded.
n. Surgical tube reconstruction is excluded.
o. In the case of a surrogate, any services related to determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, or procedures to improve the Member's ability to become pregnant are excluded; and
p. Any payment made by or on behalf of a Member who is contemplating or has entered a contract for surrogacy to a Provider or individual related to any services potentially included in the scope of surrogacy services described above is excluded.

20. **Long-term care** - 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 are excluded. "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 Prominence 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 are excluded.
21. **Maternity** - Amniocentesis is excluded, except as otherwise permitted in this EOC. Collection and banking of cord blood is not covered. Doulas are excluded.
22. **Medicaid** - Services billed with codes designated for use by state Medicaid agencies for items/services for which there are no permanent national codes but for which codes are necessary to administer the Medicaid program are excluded. Also excluded are those specific Medicaid codes mandated by state law to identify mental health services that include alcohol and drug treatment services.
23. **Medical services** -
    a. Prior authorization not provided. Services not obtained in accordance with Prominence's Prior Authorization requirements, except for Emergency care or as covered under the Coordination of Benefits provisions are excluded.
    b. Services not Medically Necessary. Services that are not deemed Medically Necessary by Prominence or not required in accordance with accepted standards of medical practice, even when ordered by a Provider are excluded.
    c. Services during excessive absence. Services obtained outside of the Service Area for an absence exceeding 90 days are excluded.
    d. No cost services. Payment for services that would normally be provided without charge, or services for which the Member would not otherwise be considered financially liable are excluded.
    e. Non-Emergency services during international travel. Benefits or services rendered outside of the United States, except for Emergency Services, are excluded.
    f. Translation of claims. All claims for treatment of a Member must be submitted in English or with an English translation. Foreign claims must include the applicable medical record in English to show proper proof of loss and evidence of payment to the Provider.
24. **Membership fees** - Membership fees charged by Providers as a condition of treatment, for example, concierge medicine, are excluded.
25. **Military related disabilities** - Care for military service-connected disabilities and conditions for which You are legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to You are excluded.
26. **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.

27. **Non-covered Providers of service** –
    a. Membership costs for health clubs, weight loss clinics, sports medicine and similar programs are excluded.
    b. 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 are excluded.
    c. Services provided by a person who lives with You in Your home or is a part of Your family are excluded.
    d. Private Hospital rooms, Custodial Care, board and care, rest homes or homemaker services are excluded. "Custodial Care" is defined as care that serves to assist an individual in the activities of daily living.
    e. Institutional care which is determined by the Prominence Medical Director to be for the primary purpose of controlling Member's environment is excluded.
    f. Domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures are excluded.
    g. Supplies, medical care, or treatment are excluded when 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 a Member by blood, e.g., sibling, parent, grandparent, child, marriage (e.g., spouse or in-law) or adoption or is normally a member of the Member's household.
    h. Charges for treatment by a Provider that are not within the scope of his/her license are excluded.
28. **Non-covered therapies/services** - Biofeedback, hypnosis, aromatherapy, aquatic therapy, massage therapy, reiki 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, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (B.E.S.T.), colonic irrigation, magnetic innervation therapy and electromagnetic therapy, CIIIT (Chronic Intermittent Intravenous Insulin Therapy) or PIVIT (Pulsat IV Insulin Therapy) are excluded.
29. **Not Listed Services or Supplies** – Any services, care or supplies which are not specifically listed in this EOC as Services and Benefits are excluded unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage.
30. **Certain drugs** –
    a. Costs related to the acquisition or use of medical marijuana are excluded.
    b. Take-home drugs and medications incidental to a Hospital admission except when provided as part of an inpatient admission are excluded.

c. Over-the-counter drugs, homeopathic, herbal medications, supplements, and other substances not requiring a prescription even if ordered by a prescription from an In-Network Provider are excluded.
d. Self-injectables, except for diabetic medications and supplies, except as otherwise permitted in this EOC are excluded.
e. The portion of the cost of drugs that are paid for using a coupon, rebate or other discount programs not affiliated with Prominence are excluded and shall not be counted toward the Member's Deductible or Out-of-Pocket Maximum.

31. **Orthopedic shoes** - Special shoes, insoles, corsets, trusses and all other such devices are excluded except as otherwise described in this EOC.
32. **Over-the-Counter Supplies** - Supplies that can be obtained without a Physician's prescription are excluded. 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.
33. **Religious counseling** - Religious or spiritual counseling is excluded.
34. **Residential Treatment** - Residential Treatment, except that which is provided by an accredited facility, is excluded.
35. **Routine Foot Care** - Except as otherwise permitted in this EOC, the cutting or removal of corns and calluses; the trimming, cutting, clipping or debriding of nails; other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone for either ambulatory or bedfast members, any other service performed in the absence of localized illness, injury or symptoms involving the feet are excluded.
36. **Saliva Testing** - Costs related to saliva testing are excluded.
37. **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.
    a. Abdominoplasty;
    b. Blepharoplasty;
    c. Body contouring (liposuction of the waist);
    d. Breast enlargement procedures such as augmentation mammoplasty and implants;
    e. Brow lift;
    f. Calf implants;
    g. Cheek/malar implants;
    h. Chin/nose implants;
    i. Collagen injections;
    j. Construction of a clitoral hood;
    k. Drugs for hair loss or growth;
    l. Face-lifting;
    m. Facial bone reduction;
    n. Feminization of torso;
    o. Hair removal;
    p. Forehead lift;
    q. Jaw reduction (jaw contouring);
    r. Hair removal (e.g., electrolysis, laser hair removal);
    s. Hair transplantation;
    t. Lip reduction;
    u. Liposuction;
    v. Lip enhancement;
    w. Masculinization of torso;

x. Mastopexy;
y. Neck tightening;
z. 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.);
aa. Nose implants;
bb. Pectoral implants;
cc. Reduction thyroid chondroplasty;
dd. Rhinoplasty;
ee. Removal of redundant skin;
ff. Rhinoplasty;
gg. Skin resurfacing (dermabrasion, chemical peel);
hh. Voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization are considered Cosmetic; and
ii. Voice therapy/voice lessons.

38. **Sexual dysfunction** - Penile implants and any related sexual devices, appliances, services, or medications for sexual dysfunction are excluded.
39. **Special training/treatment** - Sensitivity training, educational training therapy or treatment for an education requirement is excluded. Ecological or environmental medical diagnosis and/or treatment is excluded.
40. **Spinal treatment** - Vertebral Axial Decompression (VAX-D), Back-to-Back, Orthotrac Pneumatic Vest, Back Friend, spinal manipulation for Chronic conditions, maintenance, and/or preventive therapy is excluded.
41. **Third opinions** - Opinions and consultations beyond the second opinion are excluded.
42. **Travel** –
    a. Travel, accommodations, and oxygen provided while traveling on an airplane whether or not recommended or prescribed by a Provider are excluded.
    b. Costs related to room and board for the Member are excluded except if the cost is charged by the Hospital as part of a Medically Necessary inpatient Hospital admission and the expenses are incurred between the time of admission and the time of discharge, or as otherwise covered in this EOC.
    c. Costs related to room and board for individuals who are not the patient, such as family members of the Member, are excluded.
43. **Urgent Care Services** - Urgent Care Services obtained inside the Service Area by an Out-of-Network Urgent Care Facility are excluded.
44. **Vehicles** - Modifications to vehicles, the purchase of medical vehicles or ambulances and the purchase of vehicles with or without lifts or other modifications are excluded.
45. **Vision** –
    a. Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedures to alter Refraction or complications resulting from the procedure are excluded.
    b. 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 are excluded for adult Members following the month in which the Member turns 19 years of age.
    c. The furnishing or replacing of eyeglasses or contact lenses is excluded for adult Members following the month in which the Member turns 19 years of age, except when following cataract surgery.
    d. The replacement of eyeglasses or contact lenses is excluded except as otherwise described in this EOC.

e. Safety glasses required for employment are excluded.
f. Non-prescription glasses and contact lenses are excluded.
g. Tinted contact lenses not used for corrective purposes are excluded.
h. Glass lenses are excluded.
i. Non-prescription sports related protective eye wear are excluded.

46. **War-related services** - Services or supplies received because of war, declared or undeclared, international armed conflict, insurrection or terrorism are excluded.
47. **Weight Loss/Gain Services** - Special diet or food supplement programs, products or medications for weight loss and weight-loss programs are excluded. Residential Treatment programs for obesity and/or morbid obesity and/or Residential Treatment for weight gain are excluded.
48. **Work-related Injuries** - Work-related Injuries and/or Illnesses, including those not covered by a workers' compensation policy, are excluded. Injuries resulting from professional competition from which the Member is paid or would have been paid had the Member won the professional competition, are excluded.

Limitations

In the event that due to circumstances not within the control of Prominence, 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 Prominence's In-Network Provider personnel or similar causes, the rendering of Professional or Hospital Services provided under this EOC is delayed or rendered impractical, Prominence shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Prominence and In-Network Providers shall render Hospital and Professional Services provided under this EOC insofar as practical, and according to their best judgment; but Prominence and In-Network Providers 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.

Part VIII. Plan Administration

1. All In-Network Providers are independent contractors. In-Network Providers are not agents of Prominence, nor is Prominence or any of its employees, an employee or agent of In-Network Providers. Prominence 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 In-Network Provider.

2. You may, for personal reasons, refuse to accept procedures or treatment by an In-Network Provider. In-Network 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 Prominence nor the In-Network Provider will be responsible for treatment of the condition, or any services required.

3. The Premium charges for this EOC shall be determined by Prominence, 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. If premium is not received by the end of the month in which it was due, coverage will be terminated first day of the month premium was due.
    b. Only when Your Premium payment has been received are You entitled to healthcare services under this EOC. A Grace Period of 31 days will be allowed.
    c. Prominence 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 EOC.

4. Prominence reserves the right to revise this EOC and Your Schedule of Benefits in accordance with Federal or State regulation. Such revisions shall be made upon 60 days' advance written notice to the Group.

5. For the initial claim, Prominence reserves to itself and its designated administrators the right to interpret or construe the terms of this EOC, to resolve all questions concerning the status and rights of Subscribers and others under the EOC, including, but not limited to, eligibility for benefits, and to make any other determinations it deems reasonable in the administration of the EOC, the right to revise this EOC 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 with the Nevada Division of Insurance, or the U.S. Department of Labor, or Nevada Consumer Health Services, or the U.S. Department of Health and Human Services, Appeal an Adverse Benefit Determination, to have it reviewed externally (when appropriate) or to demand mediation and/or arbitration or to file a lawsuit. See Part XV.

6. The Member ID card is issued by Prominence pursuant to this EOC for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this EOC and misuses 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 EOC, the holder of the card must be a Member on whose behalf all applicable Premium charges under this EOC have been paid. Any person receiving services or benefits that he or she is not

entitled to receive pursuant to the provisions of this EOC shall be charged for such services or benefits at prevailing rates.

7. You are entitled to ask if Prominence has special financial arrangements with their contracted Providers 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 Members regarding whether Prominence contracts include In-Network Provider incentive plans that affect the use of referral services.

8. Transfer of Medical Benefits from Prior Plan.
    a. When this EOC replaces another policy, and employee or his Dependents were covered on the date the prior policy ended, insurance will become effective under this EOC 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 EOC;
        ii. The date coverage terminates under this EOC.

Part IX. Termination of Coverage

1. Group Coverage, including this EOC, may be terminated in the following ways:
    a. By Prominence, if the Group fails to pay the Premium when due, and if default continues after the Grace Period, the Group and all Members enrolled through the Group may be terminated.
    b. By Prominence, or the Group, if the Group, or a covered subsidiary, is no longer located in the State of Nevada.
    c. By Prominence if Prominence decides to discontinue the product and Prominence provides 90 days written notice.
    d. By Prominence if Prominence decides to discontinue offering group health insurance and Prominence provides 180 days written notice.

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 Prominence, if the Group is no longer eligible to have a contract with Prominence.
    c. By Prominence, if the group fails to make payment of premiums upon 31 days written notice.
    d. Prominence 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 EOC. Prominence will provide at least 30 days advance written notice to each Member who would be affected before Plan Coverage will be rescinded. Rescission will go back to the date the actual fraud took place. Rescission to inception of the plan will only occur if the act constitutes a material breach that would have prevented coverage from being offered.
    e. By Group, Subscriber or Prominence for any Dependent Member who is no longer eligible for coverage as a Dependent.
    f. By Prominence, 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. If 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.

1. **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 Prominence 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 Prominence 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.

2. **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 EOC will continue to be provided to You and Your dependents (who are otherwise covered by this EOC 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 EOC 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 EOC are provided to You.

3. **Federal Continuation**: If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues in some form) in accordance with federal law. 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:
    a. Notifying you in a timely manner of the right to elect continuation coverage.
    b. Notifying us in a timely manner of your election of continuation coverage.

Part XI. Third Party Recovery, Subrogation and Reimbursement

1. **Payment Condition**
    a. 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").
    b. 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 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.
    c. 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 all expenses (fees and costs) associated with the Plan's attempt to recover such money.
    d. 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.
    e. Prominence will not seek to recover benefits paid on Your behalf from any other first-party insurance coverage, including individual health insurance, health insurance under a franchise plan, no-fault automobile insurance, or automobile medical insurance.

2. **Subrogation**
    a. 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.
    b. 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 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.

c. 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:
    i. The responsible party, its insurer, or any other source on behalf of that party.
    ii. Any first party insurance through medical payment coverage, personal Injury protection, no- fault coverage, uninsured or underinsured motorist coverage.
    iii. Any policy of insurance from any insurance company or guarantor of a third party.
    iv. Workers' compensation or other liability insurance company.
    v. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.
d. 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 all sources listed above.
e. Prominence will not seek to recover benefits paid on Your behalf from any other first-party insurance coverage, including individual health insurance, health insurance under a franchise plan, no-fault automobile insurance, or automobile medical insurance.

3. **Right of Reimbursement**
    a. 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 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 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.
    b. 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 because 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.

c. 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).
d. 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.

4. **Participant is a Trustee Over Plan Assets**
   a. 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 because 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:
      i. 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.
      ii. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
      iii. 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.
      iv. Hold 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.
   b. 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.

5. **Excess Insurance**
   a. 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:
      i. The responsible party, its insurer, or any other source on behalf of that party.
      ii. Any first party insurance through medical payment coverage, personal Injury protection, no- fault coverage, uninsured or underinsured motorist coverage.
      iii. Any policy of insurance from any insurance company or guarantor of a third party.
      iv. Workers' compensation or other liability insurance company.
      v. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

vi. Prominence will not seek to recover benefits paid on Your behalf from any other first-party insurance coverage, including individual health insurance, health insurance under a franchise plan, no-fault automobile insurance, or automobile medical insurance.

6. **Separation of Funds**
   a. 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.

7. **Wrongful Death**
   a. 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.

8. **Obligations**

   a. It is always the Participant's/Participants' obligation, both prior to and after payment of medical benefits by the Plan:
      i. 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.
      ii. 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.
      iii. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
      iv. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
      v. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.
      vi. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
      vii. 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.
      viii. 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.
      ix. 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.
      x. 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).

xi. 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.

9. **Offset**
   a. 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.

10. **Minor Status**
   a. 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 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.
   b. 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.

11. **Language Interpretation**
   a. 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.

12. **Severability**
   a. If 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 XII. Coordination of Benefits, Third Party Payments, and Double Coverage

1. **Nonduplication**: Prominence will provide You with full healthcare services within the limits of this EOC. Prominence does not duplicate benefits or provide You with greater benefits than the actual expenses incurred. Benefits under this EOC 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**: Prominence will not pay for benefits for conditions in which coverage is available under the Workers Compensation law. Prominence 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's Appeal process. Before Prominence will consider payment of the claim, Prominence must first receive all final determinations from Workers Compensation. The Member must still follow the procedures set forth in this EOC, which includes but is not limited to obtaining Prior Authorizations.

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

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

5. **Coordination of Benefits**: Coordination of Benefits applies in cases when a Member is covered under two insurance contracts that provide similar coverage. If both contracts are issued through or by Groups and if the service You receive is covered under both contracts, Prominence will coordinate benefit payments with the other company. Prominence will pay its benefits if all state-approved guidelines are followed as stated in this EOC, which includes but is not limited to obtaining Prior Authorizations. Prior to receiving services under Coordination of Benefits, contact Prominence Customer Service at (800)863-7515. One company will provide its full benefit as primary benefit. The other company will provide secondary benefits, if necessary, to the extent of its benefit. This prevents double payment and overpayment.

   To determine which company is primary, these 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 belonging to the Group 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, falls 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 this 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 Prominence in the administration of this provision. If this EOC requires that benefits be paid for by another source and You have failed to seek payment from that source, Prominence will reduce the payments under this EOC by the amount to which You are entitled from that source. In some cases, Prominence 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 Prominence.
h. Prominence 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 has health insurance under this EOC and is entitled under Medicare Parts A and B. This Medicare COB Rule applies before any other COB provisions of the Policy.
   a. **Definitions**:
      i. 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.
      ii. 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.
      iii. ESRD - End Stage Renal Disease.
      iv. Medicare Benefits - benefits for services and supplies which the Member receives or is eligible for under Medicare, Parts A or B.
   b. **Effect on Benefits**:
      If, according to the rules for determining benefits:
      i. Prominence has primary responsibility for the Member's claims, and then Prominence pays benefits first.
      ii. Prominence has secondary responsibility for the Member's claims;
         1. First, Medicare benefits are determined or paid; and
         2. Then, Prominence benefits are paid.

      For services payable under both plans, the combined Prominence and Medicare benefits will not exceed 100% of the expense incurred.
   c. **Rules for determining order of benefits**:
      i. **For the Subscriber or the Eligible Employee** - If all the following apply, then Prominence has primary responsibility for Your claims:
         1. The Member is age 65 or older;
         2. The Member is eligible for Medicare Parts A and B, solely because of age; and
         3. 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.

If 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 Prominence Plan has secondary responsibility.

ii. **For a Dependent Spouse** - If all the following apply, Prominence has primary responsibility for a dependent spouse's claims:
   1. The spouse is age 65 or older;
   2. The spouse is eligible for Medicare, Parts A and B, solely because of age; and
   3. 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 Member is eligible for Medicare Parts A and B, because of age, this Prominence Plan has secondary responsibility.

iii. **For a Disabled Person** - Prominence has primary responsibility for the claims of a Member:
   1. 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
   2. Whose employer normally employed 100 or more employees on a typical business day during the previous Calendar Year;

iv. **For a Member with End-Stage Renal Disease** - Prominence has primary responsibility for the claims of a Member:
   1. 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
   2. Who is in the Waiting Period (up to 3 months) prior to the coordination period or in the coordination period itself;

   Prominence 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.

v. **Beginning of Coordination Periods**:
   1. 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:
      (a) The first month of dialysis; or
      (b) 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.
   2. 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.

vi. **End of Coordination Periods**:
   1. 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.
   2. The coordination period for the following individuals ends with the earlier of the 12 months of entitlement to or eligibility for Medicare Part A:

(a) 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 based on ESRD during December 1989 and January 1990.
(b) Members who become entitled to, or eligible for, Medicare Part A solely based on ESRD after January 1995.

3. 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 based on ESRD from February 1990 through July 1994.
4. The coordination period ends January 1, 1996, for Members who become entitled to, or eligible for, Medicare Part A solely based on ESRD from August 1994 through January 1, 1995.
5. 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.

This lien shall remain in effect until the Plan is repaid. You or Your family Member agree to pay to the Plan benefits paid on Your or Your family Member's behalf out of any recovery made from the third party or insurer. The Plan's right to an equitable lien or a constructive trust shall be given priority over any funds paid by a third party to You or Your family Member concerning the injury or sickness, including a priority over any claim for non-medical or dental charges, attorneys' fees, or other costs and expenses.

When You accept payment of medical expenses (i.e., benefits) for an injury or illness caused or contributed to by a third party (hereinafter referred to as a "Third Party Injury") You agree to the following:

1. Prominence's right to recover benefits paid on Your behalf will be contingent upon You being made whole for the Third-Party Injury.
2. Prominence will not seek to recover benefits paid on Your behalf from any other first-party insurance coverage maintained by You, including individual health insurance, health insurance under a franchise plan, no-fault automobile insurance, or automobile medical insurance.
3. Once You have received a Third-Party Injury recovery, You agree to reimburse Prominence HealthFirst for 100% of the benefits paid on Your behalf from all amounts You receive from a third party or third-party insurer (whether by lawsuit, settlement, or otherwise) in connection with the Third-Party Injury.
4. If Your recovery from the third-party is less than the amount of benefits Prominence has paid on Your behalf, You agree to reimburse Prominence 100% of the amounts recovered by You. If You make any request or demand for payment to a third party (whether formal or informal) in connection with a Third-Party Injury, You will notify Prominence in writing within five (5) business days of making that request. You will also notify Prominence in writing within five (5) business days of receiving any payment from a third party (or third-party insurer) in connection with a Third-Party Injury.

5. Within five (5) business days of Your receipt of any payment from a third-party (or a third- party insurer) in connection with a Third-Party Injury, You shall deposit 100% of the amounts recovered by You into a bank account. Amounts owed to Prominence under this Agreement shall be held in constructive trust for Prominence and shall remain in the bank account until paid to Prominence pursuant to this Agreement. Prominence shall have the right of equitable restitution for any medical benefits paid or provided to You, after You have been made whole.
6. If You fail to bring legal action against a third party (or a third-party insurer) to recover payment of health care expenses incurred in connection with a Third-party Injury, Prominence may institute a lawsuit against such third party in its own name or in Your name. Prominence shall receive an assignment from You of Your rights to recover against any third party (or third-party insurer) with respect to any Third-party Injury. Prominence Shall be entitled to retain from any resulting judgment or settlement the amount of benefits paid or provided by Prominence to You, together with all court costs and attorneys' fees incurred by Prominence after You have been made whole.
7. You agree to take all reasonable measures to help Prominence recover benefits paid or incurred on Your behalf in connection with a Third-Party Injury. You shall execute and deliver all such instruments and papers as may be required (including, but not limited to, executing an assignment of Your claims in favor of Prominence) and will do whatever else is needed to secure Prominence rights under this Agreement. If You do not comply with this Agreement, You will be responsible for the medical benefits paid by Prominence HealthFirst and any legal expenses incurred by Prominence to enforce its subrogation rights under this Agreement.

7. **Provider of health care whose contract with Prominence is terminated during the course of the medical treatment**:
   a. The Member may continue to obtain medical treatment for the medical condition from the Provider pursuant to this section, if:
      i. The Member is actively undergoing a Medically Necessary Course of Treatment; and
      ii. The Provider and the Member agree that the continuity of care is desirable.
   b. The Provider is entitled to receive reimbursement from Prominence for the medical treatment the Provider provides to the Member pursuant to this section, if the Provider agrees:
      i. To provide medical treatment under the terms of the contract between the Provider and Prominence regarding the Member, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the Provider and Prominence; and
      ii. Not to seek payment from the Member for any medical service provided by the Provider that the Provider could not have received from the Member were the Provider still under contract with Prominence.
   c. The coverage required by subsection a must be provided until the later of:
      i. The 120th day after the date the contract is terminated; or
      ii. If the medical condition is pregnancy, the 45th day after:
         1. The date of delivery; or
         2. If the pregnancy does not end in delivery, the date of the end of the pregnancy.
   d. The requirements of this section do not apply to a Provider if:

i. The Provider was under contract with Prominence and Prominence terminated that contract because of the medical incompetence or professional misconduct of the Provider; and
ii. Prominence did not enter into another contract with the Provider after the contract was terminated pursuant to paragraph (i).

Part XIII. Member Rights and Responsibilities

1. **Confidentiality of Healthcare Records**: Information from Your medical records and information received from 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 Prominence 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 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 Prominence coverage and benefits. You are encouraged to contact Prominence Customer Service at (800)863-7515 with any questions or problems as soon as they arise.

   Prominence is committed to providing prompt and responsive service to all Members. We have established this Internal Claim and Appeal Procedure to assist You if You have a problem or concern regarding any aspect of Prominence services. The Complaint and Appeal Procedure is provided in this EOC and is also available upon request from Prominence Customer Service.

4. **Notice of Claim**: You should not have to make payments for Medically Necessary Covered Services to In-Network Providers except for the required Copayments, Calendar Year Deductible, or Coinsurance. If, however, You have paid for services which are covered by this EOC, You may be reimbursed providing:
   a. You provide Prominence 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. Pre-authorized reimbursement for Centers of Excellence Travel Expenses must be submitted within 60 days of being incurred. Requests should be submitted to:
      Prominence Health Plan
      Claims Department
      1510 Meadow Wood Lane
      Reno, NV 89502

5. **Healthy Lifestyle**: As a Prominence Member, You have access to medical care and coverage of medical care as described in this EOC. 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 Providers.

6. **Maintain Appointments**: You have a responsibility to keep the appointment made by or for You with In-Network Providers. If You are unable to keep an appointment, always try to notify the In-Network 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 EOC, 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 Providers need 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, Providers and the above rights and responsibilities. To obtain information about Providers who participate with Prominence, You can call Prominence Customer Service at (800)863-7515 or find this information at 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 Prominence and its Providers need to care for them.

10. **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

    Division of Insurance Toll Free: 888-872-3234

Part XIV. Internal Claims and Appeal Procedures

The following Member Claims and Appeals Procedures[1] have been developed to assure a timely and appropriate response to a Member's concerns. Additionally, Prominence will consider the clinical urgency of the situation as it relates to the timeliness of responding to Complaints and Appeals. Prominence Customer Service is available between 8 a.m. and 5 p.m. Monday through Friday at (800)863-7515 to assist the Member.

1. **Summary of the Claims and Appeals Process**
    a. **Claims**. The Claims and Appeals process begins when You or Your Authorized Representative, including Your Provider, requests a Prior Authorization or submits a Claim for payment. This is called a Claim. If we deny the Claim, we issue an Adverse Benefit Determination.
    b. **Complaints**. If you wish to address a Complaint regarding Prominence or services provided by a contracted Provider, you may call Prominence Customer Service, send a letter to Prominence or submit the Complaint or Inquiry to Prominence at ProminenceHealthPlan.com.
    c. **Appeal**. If you wish to Appeal an Adverse Benefit Determination, you may do so by sending the Appeal through the mail or submitting the Appeal at ProminenceHealthPlan.com.
    d. **External Review**. If, during the first level of Appeal, we uphold our decision in the Adverse Benefit Determination, you may request an external review to the State of Nevada Office of Consumer Health Assistance (OCHA) which will assign an Independent Review Organization (IRO). The IRO will review the facts of the Claim and approve, modify, or reverse the Adverse Benefit Determination.

2. **Definitions**
    a. **Adverse Benefit Determination** – A determination made by Prominence which includes, but is not limited to a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on, among other things:
        i. A determination that an individual is not eligible for coverage (e.g., Rescission), or
        ii. The refusal to pay a Claim, in whole or in part, due to the terms of a coverage document regarding Deductibles, Copayments, Coinsurance, or other cost sharing requirements.
    b. **Appeal**: A written request to Prominence to change an Adverse Benefit Determination.
    c. **Claim**: Any request for benefits or services under this EOC.
    d. **Complaint or Inquiry**: Any communication that is not subject to an Adverse Benefit Determination and that requests redress concerning an action or a failure to act or questions a Plan interpretation by Prominence.

3. **Claims**
    a. **Types of Claims –** There are four types of Claims: Prior Authorization Request (Pre-Service Claim), Post-Service Claim, Concurrent Review (Concurrent Care Decisions), Urgent Request for Care (Urgent Care Claim):
        i. **Prior Authorization Request (Pre-Service Claim)**: A request for medical care or treatment that requires approval before the medical care or treatment is received. Please see the Services and Benefits Section of this EOC or Your Schedule of Benefits to determine whether a Prior Authorization is required for a particular service.

[1] These Claims and Appeals Procedures comply with 29 CFR §2560.503-1, 45 CFR §147.136 and NRS 695G.200-.310

1. For Prior Authorization Requests, Prominence will notify You (or Your Authorized Representative) of the Claim decision within a reasonable period of time appropriate to the medical circumstances but no longer than 15 calendar days after Prominence receives the Claim, unless matters beyond the control of Prominence require an extension of time, in which case, Prominence has up to an additional 15 calendar days to process the Prior Authorization request. If an extension of time to process the request 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 Prominence is to render its decision.
2. 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 Prominence after receiving the notice. If all the needed information is received within the 45-day timeframe, Prominence will notify You of the decision within 15 days after the information is received.
3. If You (or Your Authorized Representative) fail to follow the Plan's procedures for filing a Pre- Service Claim, Prominence 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 an Urgent Request for Care, as defined above) after receiving the Claim. This notice may be provided orally unless You (or Your Authorized Representative) request written notification.

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

1. Post-Service Claims are Claims for reimbursement or payment that are filed after medical care has been received. If Your Post-Service Claim is denied, You (or Your Authorized Representative) will receive a notice from Prominence within 30 calendar days after Prominence receives the Claim. This period may be extended one time by Prominence for up to 15 days, if Prominence both determines that such an extension is necessary due to matters beyond the control of Prominence and notifies the claimant, prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which the plan expects to render a decision.
2. 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 Prominence after receiving the notice. If all the needed information is received within the 45-day timeframe, Prominence will notify You of the decision within 15 days after the information is received.

iii. **Concurrent Review (Concurrent Care Decisions)**: An ongoing course of treatment previously approved by Prominence for a specific period of time or number of treatments.

1. Any reduction or termination by Prominence of a course of treatment previously approved by Prominence (other than a Plan Amendment or enrollment termination) shall constitute an Adverse Benefit Determination. Prominence will notify you of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow You (or your Authorized Representative) to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. 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 an Urgent Request for Care (as defined below),Prominence will make a determination on Your request within 24 hours from receipt of Your request, provided such request is made to Prominence at least 24 hours prior to the expiration of the previously approved course of treatment. If Your request to extend a course of treatment beyond the period of time or number of treatments previously approved does not involve an Urgent Request for 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).

iv. **Urgent Request for Care (Urgent Care Claim):** Any Claim for medical care or treatment in which a delay in treatment could:

1. Jeopardize the life of the Member;
2. Jeopardize the ability of the Member to regain maximum function;
3. Cause the Member to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
4. In the case of a pregnant woman, cause serious jeopardy to the health of the fetus(es)

Prominence in consultation with Your treating physician, will decide if the Claim is an Urgent Request for Care. Prominence will notify You (or Your Authorized Representative) of the Claim decision as soon as practicable, but no later than 72 hours after receiving the Urgent Request for Care. However, if necessary, information is missing from the Claim, Prominence will notify You (or Your Authorized Representative) after receiving the Claim to specify what information is needed as soon as possible, but not later than 24 hours after receipt of the Claim by Prominence. Determinations of Urgent Requests for Care may be provided orally, followed within three calendar days by written or electronic notification.

4. **How to File a Claim**

To file a Claim, a Member must either:

i. download a copy of the Claim form from our website: ProminenceHealthPlan.com; or
ii. request a Claim form from Prominence within 20 days after charges are incurred, or as soon as reasonably possible.

Prominence will send the Claim form to the Member within 15 days after receiving the request. Prominence 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 Prominence may reasonably require.

5. **Where to Send a Claim**

Send completed Claim forms and the original bills to:

Prominence Health Plan
1510 Meadow Wood Ln.
Reno, NV 89502

6. **Payment of Claim**

If all the information needed to process the Claim is received, the Claim shall be approved or denied no later than 30 days after receipt of the Claim. If the Claim is approved, Prominence shall pay the Claim within 30 days after it is approved. If the approved Claim is not paid within that period, Prominence shall pay interest on the 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 Prominence from any further obligation. Prominence reserves the right to allocate the Deductible, Copayment and Coinsurance, as applicable, 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.

7. **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 within 10 days after the decision, and will include all 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). Prominence 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 an Urgent Request for Care, a description of the expedited review process applicable to such Claim.

Para obtener asistencia en Español, llame al: (775)770-9310 / (800)863-7515. Los avisos están también dis ponibles en Español a petición.

8. **Complaints**

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

9. **Appeals**

a. **How to File an Appeal:**

i. 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 within 180 calendar days after notification of Your denial notice. Send completed written Appeals to:

Prominence Health Plan
Attn: Appeals and Grievance Department
1510 Meadow Wood Lane
Reno, NV 89502

ii. An Adverse Benefit Determination for an Urgent Request for Care may be Appealed orally by a Provider. In this case, if 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 Request for Care, you should also inform Prominence that you believe Your Appeal should be expedited.

iii. Prominence's initial Claim determination will be final and binding if Prominence does not receive an Appeal within 180 days. 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 will assign a representative from the Appeals Department to assist You (or Your Representative) through the Appeal process. The Appeals Department will review the Appeal.

iv. You (or Your Authorized Representative) may submit written comments, documents, records, or other information relating to Your Appeal and the Appeals Department will re-examine all facts and make a determination with respect to the denial.

v. As a Prominence Member,
   1. You may request reasonable access to, and copies of, all documents, records, and other information relevant to Your Appeal, free of charge.
   2. You may request reasonable access to all documents submitted on Your behalf to the Appeals Department.
   3. You may also obtain a copy of the benefit provisions, guidelines, protocols, or other similar criterion on which the Appeal decision was based.

vi. 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 receives notification of a Member's Appeal and ends on the date Prominence notifies the Member of its decision. Given the tight time schedules established in the Claims procedures, Prominence can extend time deadlines. Additional materials submitted after the time has expired for submitting Your Appeal cannot be considered.

10. **What to Expect After You File Your Appeal**

i. 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 Appeals Department will consult with an appropriate Provider, in the same or a similar specialty, who was not involved in the initial denial of Your Claim with respect to an Appeal involving medical judgment. The Appeals Department will not afford deference to the initial Claim denial.

ii. In the event new or additional evidence is considered, relied on, or generated by the Plan or Appeals 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 Appeals 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 Appeals Department. You (or Your Authorizes Representative) may appear in person or by teleconference to present information.

iii. Prominence will provide written or electronic notification of its decision within 30 calendar days after it receives an Appeal for a Prior Authorization Request and 60 days for a post-service Appeal.

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

v. Every notice of an Adverse Benefit Determination on Appeal will be set forth in a manner designed to be understood by You within 30 days, and will include all the following that pertain to the determination:

1. 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). Prominence 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;
2. The specific reason or reasons for the Adverse Benefit Determination on Appeal;
3. Reference to the specific Plan provisions upon which the determination is based;
4. A statement that you may request access to, and copies of, all documents, records, and all other information relevant to Your Claim;
5. 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;
6. 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;
7. A statement describing the next level of Appeals procedures offered by the Plan and Your right to obtain information about such procedures; and
8. 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.

11. **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.

12. **External Review**

a. If Prominence has 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 this notice to the:

Office for Consumer Health Assistance (OCHA)
555 East Washington #4800
Las Vegas, NV 89101
Phone: (702)486-3587 / (888)333-1597, or Fax (702)486-3586
Web: dhhs.nv.gov/Programs/CHA/

13. **Standard External Review**

i. The Member may submit a request for an External Review of an Adverse Benefit Determination under this section only after the Member has exhausted all applicable internal Prominence Appeals Procedures provided under this Plan or if Prominence fails to issue a written decision to the Member within thirty (30) days after the date the Appeal was filed and the Member or Member's Authorized Representative did not request or agree to a delay or, if Prominence agrees to permit the Member to submit the Adverse Benefit Determination to OCHA without requiring the Member to exhaust all internal Prominence Appeals Procedures. In such events, the Member shall be considered to have exhausted the applicable internal Prominence Appeals Process. The Member must file the request for external review no later than four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination.

ii. Within five (5) days after OCHA receives a request for External Review, OCHA shall notify the Member, the Member's Authorized Representative and Prominence that such request has been received and filed. As soon as practical, OCHA shall assign an Independent Review Organization (IRO) to review the case.

iii. Within five (5) business days after Prominence receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, Prominence will make a preliminary determination of whether the case is complete and eligible for External Review. Within one (1) business day of making such a determination, Prominence will notify in writing, the Member, or the Member's Authorized Representative and OCHA, accordingly. If Prominence determines that the case is incomplete and/or ineligible, Prominence will notify the Member in writing of such determination. Such notice shall include the required additional information or materials needed to make the request complete and, if applicable, state the reasons for ineligibility and state that such determination may be Appealed to OCHA. Upon Appeal, OCHA may overturn Prominence's determination that a request for External Review of an Adverse Benefit Determination is ineligible, and submit the request to External Review, subject to all the terms and provisions of this Plan and applicable Nevada law and regulation.

iv. Within one (1) business day after receiving the confirmation of eligibility for External Review from Prominence, OCHA will assign the IRO accordingly and notify in writing the Member or the Member's Authorized Representative and Prominence that the request is complete and eligible for External Review and provide the name of the assigned IRO.

v. Within five (5) days after receiving notification specifying the assigned IRO from OCHA, Prominence shall provide to the selected IRO all documents and materials relating to the Adverse Benefit Determination, including, without limitation:
    1. Any medical records of the Member relating to the Adverse Benefit Determination;
    2. A copy of the provisions of the healthcare Plan upon which the Adverse Benefit Determination was based;
    3. Any documents used and the reason (s) given by Prominence's Managed Care Program for the Adverse Benefit Determination; and
    4. If applicable, a list that specifies each Provider who provided healthcare to the Member and the corresponding medical records from the Provider relating to the Adverse Benefit Determination.

vi. Within five (5) days after the IRO receives the required documentation from Prominence, they shall notify the Member or the Member's Authorized Representative, if any additional information is required to conduct the review. If additional information is required, it must be provided to the IRO within five (5) days after receiving the request. The IRO will forward a copy of the additional information to Prominence within one (1) business day after receipt. The IRO shall approve, modify, or reverse the Adverse Benefit Determination within fifteen (15) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:
    1. Member;
    2. Member's Physician;
    3. Member's Authorized Representative, if any; and
    4. Prominence.

14. **Expedited External Review**
    a. A request for an Expedited External Review may be submitted to OCHA after it receives proof from the Member's Provider that the Adverse Benefit Determination concerns:
        i. An inpatient admission;
        ii. Availability of inpatient care;
        iii. Continued stay or health care service for Emergency Services while still admitted to an inpatient facility; or
        iv. Failure to proceed in an expedited manner may jeopardize the life or health of the Member.
    b. Prominence will immediately determine if the request meets the requirements for Expedited External Review pursuant to this section and notify the Member or the Member's Authorized Representative and OCHA of the determination. If Prominence determines the request to be ineligible, the Member will be notified that the request may be Appealed to OCHA.
    c. OCHA shall approve or deny this request for Expedited External Review within seventy-two (72) hours after receipt of the above required proof. If OCHA approves the request, it shall assign the request to an IRO no later than one (1) business day after approving the request. Prominence will supply all relevant medical documents and information used to establish the Adverse Benefit Determination to the IRO within twenty-four (24) hours after receiving notice from OCHA. If Prominence fails to provide the information within the specified time, the IRO may terminate the External Review and reverse the Adverse Benefit Determination. The IRO shall complete its Expedited External Review within forty-eight (48) hours after

initially being assigned the case unless the Member or the Member's Authorized Representative and Prominence agree to a longer time period.

d. The IRO shall notify the following parties no later than twenty-four (24) hours after completing its Expedited External Review:
    i. Member;
    ii. Member's Physician;
    iii. Member's Authorized Representative, if any; and
    iv. Prominence.
e. The IRO shall then submit a written copy of its determination within forty-eight (48) hours to the applicable parties listed above.

15. **Request for an External Review Due to Denial of Experimental or Investigational Healthcare Service or Treatment**

A Standard or Expedited External Review of an Adverse Benefit Determination due to a requested or recommended healthcare service or treatment being deemed experimental or investigational, is available in limited circumstances as outlined in the following sections.

a. **Standard External Review - Denial of Experimental or Investigational Treatment**
    i. You (or Your Authorized Representative) may within four (4) months after receiving notice of an Adverse Benefit Determination subject to this section, submit a request to OCHA for an External Review.
    ii. OCHA will notify Prominence and/or any other interested parties within one (1) business day after the receipt of the request for External Review. Within five (5) business days after Prominence receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, Prominence will make a preliminary determination of whether the case is complete and eligible for External Review.
    iii. Within one (1) business day of making such a determination, Prominence will notify You (or Your Authorized Representative) and OCHA, in writing. If Prominence determines that the case is incomplete and/or ineligible, Prominence will notify You in writing of such determination. Such notice shall include the required additional information or materials needed to make the request complete and, if applicable, state the reasons for ineligibility and state that such determination may be appealed to OCHA. Upon appeal, OCHA may overturn Prominence's determination that a request for External Review of an Adverse Benefit Determination is ineligible, and submit the request to External Review, subject to all the terms and provisions of this Plan and applicable Nevada law and regulation.
    iv. Within one (1) business day after receiving the confirmation of eligibility for External Review from Prominence, OCHA will assign the IRO and notify You (or the Your Authorized Representative) and Prominence in writing that the request is complete and eligible for External Review and provide the name of the assigned IRO. Prominence, within five (5) days after receipt of such notice from OCHA, will supply all relevant medical documents and information used to establish the Adverse Benefit Determination to the assigned IRO who will select and assign one or more clinical reviewers to the External Review.
    v. The IRO shall approve, modify, or reverse the Adverse Benefit Determination pursuant to this section within twenty (20) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:

1. Member;
2. Member's Physician;
3. Member's Authorized Representative, if any; and
4. Prominence.

b. **Expedited External Review - Denial of Experimental or Investigational Treatment**

i. You (or Your Authorized Representative) may request in writing, an internal Expedited Appeal by Prominence, and an Expedited External Review from OCHA simultaneously if the Adverse Benefit Determination of the requested or recommended service or treatment is determined by Prominence to be experimental or investigational, and, if the treating Provider certifies, in writing, that such service or treatment would be less effective if not promptly initiated.

ii. An oral request for an Expedited External Review may be submitted directly to OCHA upon the written submission of proof from the Member's Provider to OCHA that such service or treatment would be significantly less effective if not promptly initiated. Upon receipt of such request and proof, OCHA shall immediately notify Prominence accordingly.

iii. Prominence will immediately determine if the request meets the requirements for Expedited External Review pursuant to this section and notify You (or Your Authorized Representative) and OCHA of the determination. If Prominence determines the request to be ineligible, the Member will be notified that the request may be appealed to OCHA.

iv. If OCHA approves the request for Expedited External Review, it shall immediately assign the request to an IRO and notify Prominence. The IRO has one (1) business day to select one or more clinical reviewers. Prominence must submit the documentation used to support the Adverse Benefit Determination to the IRO within five (5) business days. If Prominence fails to provide the information within the specified time, the IRO may terminate the External Review and reverse the Adverse Benefit Determination.

v. The Member or Member's Authorized Representative may, within five (5) business days after receiving notice of the assigned IRO, submit any additional information in writing to the IRO. Any information submitted by the Member or the Member's Authorized Representative after five (5) business days to the IRO may be considered as well. Any information received by the Member or the Member's Authorized Representative must be submitted to Prominence by the IRO within one (1) business day.

vi. The clinical reviewers have no more than five (5) days to provide an opinion to the IRO. The IRO has forty-eight (48) hours to review the opinion of the clinical reviewers and make a determination. The IRO shall notify the following parties no later than twenty-four (24) hours after completing its External Review:
   1. Member;
   2. Member's Physician;
   3. Member's Authorized Representative, if any; and
   4. Prominence.

vii. The IRO shall then submit a written copy of its determination within forty-eight (48) hours to the applicable parties listed above.

16. **Time Limit for Taking Legal Action Concerning Denied Benefits**

a. No legal action for benefits under the Plan 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 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'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 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 met the exception requirements listed above, You have the right to resubmit Your Claim and pursue an internal Appeal.

b. No legal action may be commenced or maintained against the Plan more than one (1) year from the earlier of the date on which the services requested were denied by the Appeals Committee on review or one (1) year from the date the Appeals Committee should have filed its written response to Your Appeal of the denied Claim.

c. To file a Complaint with the Office for Consumer Health Assistance You must submit Your Complaint in writing to:

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

17. **NOTICE OF APPEAL RIGHTS UNDER NEVADA LAW**

You have a right to Appeal any decision Prominence 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:

a. Do not understand the reason for the denial;
b. Do not understand why the health care service or treatment was not fully covered;
c. Do not understand why a request for coverage of a health care service or treatment was denied;
d. Cannot find the applicable provision in Your Benefit Plan Document;
e. Want a copy (free of charge) of the guideline, criteria, or clinical rationale that we used to make our decision; or
f. 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 Health Plan, 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.

Emergency Experimental or Investigational Medical Conditions: In the event of Emergency experimental or investigational medical conditions, the timeframe for completing the expedited review for Urgent Requests for Care either internally or externally does not apply. Emergency medical conditions are those that would jeopardize the life or health of the Member or would jeopardize the Member'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 Member'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 Member will be required to complete the expedited review of the denied Claim before medical services are provided.

Prominence Health Plan
1510 Meadow Wood Lane
Reno, NV 89502
Telephone: (800)863-7515

Office for Consumer Health Assistance
555 East Washington Avenue, Suite 4800
Las Vegas, NV 89101
(702)486-3587 or (888)333-1597

Part XV. 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:

Compliance Officer
Prominence Health Plan
1510 Meadow Wood Lane
Reno, Nevada 89502
t: (775)770-9300

WHO WE ARE

This Notice describes the privacy practices of Prominence and applies to any health services You receive through Prominence.

OUR PRIVACY OBLIGATIONS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules to carry out this law (Privacy Rules), require Prominence 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 Privacy Notice describes the privacy policies of Prominence. These policies protect medical information relating to Your past, present and future medical conditions, health care treatment and payment for that treatment (Protected Health Information or PHI).

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

WHEN PREFERRED MUST DISCLOSE YOUR PHI

Prominence must disclose Your PHI:

1. To You;
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 Prominence 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

Prominence protects personal health information (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 PREFERRED MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

Prominence may use and/or disclose Your PHI as follows:

For Treatment. Prominence does not provide medical treatment directly, but it may disclose Your PHI to a health care Provider who is giving treatment. For example, Prominence may disclose the types of prescription drugs You currently take to an Emergency room Provider, if You are unable to provide Your medical history due to an accident. In addition, We may contact You to tell You about other health-related benefits and services that might interest You.

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

For Healthcare Operations. Prominence may use and disclose Your PHI to make sure Prominence is well run, administered properly, and does not waste money. For example, Prominence may use information about Your claims to project future benefit costs or audit the accuracy of its claims processing functions.

Prominence may also disclose Your PHI for a claim under a stop-loss or re-insurance policy. Among other things, Prominence may also use Your 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 laws may apply to the use or disclosure of Your PHI. Prominence will comply with these state or federal laws where they are more protective of Your privacy.

For Payment. Prominence may use and disclose PHI, as needed, to pay for Your medical benefits. For example, Prominence may tell a doctor whether You are eligible for coverage or what percentage of the bill Prominence might pay. Prominence may also use or disclose Your 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.

To Your Other Health Care Providers. We may also share PHI with Your doctor and other health care Providers when they need it to provide treatment to You, to obtain Payment for the care they give to You, 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. Prominence may hire third parties that may need Your PHI to perform certain services on behalf of Prominence. These third parties are “Business Associates” of Prominence. Business Associates must protect any PHI they receive from, or create and maintain on

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

To Personal Representatives. Prominence may disclose Your PHI to someone who is Your personal representative. Before Prominence will give that person access to Your PHI or allow that person to take any action on Your behalf, it will require him/her to give proof that he/she may act on Your 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, Prominence may not disclose certain information to the parents. Prominence 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. Prominence may contact You to provide information about treatment alternative or other health-related benefits or services that may be of interest to You.

For Public Health Purposes. Prominence 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. Prominence may report information about victims of abuse, neglect, or domestic violence to the proper authorities.

For Health Oversight Activities. Prominence 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. Prominence may disclose PHI to an order of a court or administrative agency, but only to the extent expressly authorized in the order. Prominence may also disclose PHI

in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if Prominence has received adequate assurances that the information to be disclosed will be protected. Prominence may also disclose PHI in a lawsuit if necessary for payment or health care operations purposes.

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

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

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

For Limited Data Sets. Prominence 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. Prominence may disclose PHI to avert a serious and imminent threat to Your health or safety or that of members of the public.

For Special Governmental Functions. Prominence 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. Prominence may disclose PHI for workers' compensation if necessary to comply with these laws.

For Research. Prominence may disclose PHI for research studies, subject to special procedures intended to protect the privacy of Your PHI.

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

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

Written Authorization. In all other situations Prominence will not use or disclose Your PHI without Your written authorization. The authorization must meet the requirements of the Privacy Rules. If You give Prominence a written authorization, You may cancel Your authorization, except for uses or disclosures that have already been made based on Your authorization. Written "revocation" statements must be submitted to our Privacy Officer at the address listed above.

You may not, however, cancel Your authorization if it was obtained as a condition for obtaining insurance coverage and if the cancellation will interfere with the insurer's right to contest Your claims for benefits under the insurance policy. Prominence may condition Your enrollment or eligibility for benefits on Your signing an authorization, but only if the authorization is limited to disclosing information necessary for underwriting or risk rating determinations needed for Prominence to obtain insurance coverage.

Highly Confidential Information. Federal and state laws require special privacy protections for certain highly confidential information about You ("Highly Confidential Information"), including any portion of Your 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 infection(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) InVitro Fertilization (IVF). Before we share Your Highly Confidential Information for a purpose other than those permitted by law, we must obtain Your written permission.

For Marketing. We must also obtain Your written permission (authorization) prior to using Your PHI to send You any marketing materials. However, we may communicate with You about products or services related to Your treatment, care coordination, or alternative treatments, therapies, health care Providers, or care settings without Your permission. For example, we may not sell Your PHI without Your written authorization.

THE MEMBER'S INDIVIDUAL RIGHTS

You have certain rights under the Privacy Rules relating to Your PHI maintained by Prominence. All requests to exercise those rights must be made in writing to the Privacy Officer. Providers keep their own records, and You must make Your requests relating to You PHI in those records directly to that Provider. Your rights are:

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

Right to Request Restrictions and Confidential Communications. You have the right to request that Prominence communicate with You in a confidential manner, for example, by sending information to an alternative address or by an alternative means. Prominence 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 File a Privacy Complaint. If You believe Your rights have been violated, You have a right to file a written complaint with Prominence's Privacy Officer or with the Secretary of the DHHS. Prominence will not retaliate against You for filing a complaint and cannot condition Your enrollment or Your entitlement to benefits on Your waiving these rights. If Your complaint is with an insurer, You may file a complaint with the individual named in their Notice of Privacy Practices to receive complaints. If Your complaint is with Prominence, You may submit Your complaint to the Privacy Official at the address at the end of this Privacy Notice.

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

Right to Receive a Paper Copy of This Privacy Notice upon Request. You have a right to obtain a paper copy of this Privacy Notice upon request. To request a paper copy of the Privacy Notice, contact the Prominence Privacy Officer.

HEALTH INFORMATION NOT COVERED BY THIS PRIVACY NOTICE

This Privacy Notice does not cover:

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

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

Complaints. If You believe that Prominence has violated Your privacy rights, are concerned that Prominence has violated Your privacy rights, or disagree with a decision that Prominence made about access to Your PHI, You may file a Privacy Complaint with Prominence or with the Secretary of the Department of Health and Human Services.

To file a Privacy Complaint with Prominence, You must submit Your Privacy Complaint in writing to:

Compliance Officer
Prominence Health Plan
1510 Meadow Wood Lane
Reno, NV 89502
t: (775)770-9300

To file a Privacy Complaint with the Secretary of the Department of Health and Human Services, You must submit Your Complaint in writing within 180 days to:

Michael Leoz, Regional Manager
Office for the Civil Rights (Region IX - Nevada)
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
t: (800)368-1019
f: (415)437-8329

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

Consumer Health Assistance
555 East Washington Avenue, Suite 4800
Las Vegas, NV 89101
t: (702)486-3587 or (800)333-1597

Part XVI. General Provisions

1. **Entire Contract**: This EOC, the application, and the individual enrollment form, constitute the entire Contract between Prominence, the Subscriber, and enrolled Dependents, and as of the effective date of this EOC, supersedes all other agreements between the parties.

2. **Administration of Contract**: Prominence reserves to itself and its designated administrators the exclusive right to interpret or to construe the terms of this EOC to resolve all questions concerning the status and rights of Members and others under the EOC, 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 You without written consent of Prominence. Benefits payable under the EOC 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 EOC. Notwithstanding the foregoing, Prominence reserves the right to make payment directly to the covered person and to refuse to honor such direction and assignment. No payment by Prominence pursuant to such direction shall be considered recognition by Prominence of a duty or obligation to pay a Provider of medical services or supplies except to the extent Prominence chooses to do so.

4. **Amendment**: Prominence may amend this EOC in accordance with the provisions contained herein.

5. **Litigation for Payment**: You may not sue Prominence for refusing to pay for services unless You start the suit within one (1) year from the date on which the services were provided or requested and you have exhausted all remedies provided in this EOC, including the internal and external appeals procedures and arbitration processes.

6. **Notice**: When a notice is required under this EOC, it must be mailed to:
   Prominence Health Plan
   Customer Service
   1510 Meadow Wood Lane
   Reno, NV 89502
   and to the Group and/or You at the most recent address on file with Prominence. You are required to inform Prominence of any change of address.

7. **Clerical Error/Return of Overpayment**: Clerical error, whether of the Group or Prominence 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 reimbursement amount, Prominence 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 Prominence Customer Service.

9. **Subtitles and Gender**: The subtitles included in this EOC 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 EOC 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 EOC.

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

Part XVII. Mediation and Arbitration Agreement

1. **Dispute Resolution**. In consideration of the mutual promises set forth herein, the Parties agree that 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 Prominence (collectively, the "Parties") shall submit all disputes, claims or controversies relating to or arising out of this EOC to mediation prior to the appointment of any arbitrator. Prominence 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 during 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 Prominence 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 all disputes, claims, or controversies arising out of or relating to this EOC shall be submitted to mediation, and if the matter is not resolved through mediation, then it shall be submitted to final and binding arbitration. Prominence will pay the arbitrator for his or her costs, fees, or expenses. Any dispute, claim or controversy arising out of or relating to the EOC, 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. Prominence agrees to pay for all necessary arbitration fees. If the EOC 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, if 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 Prominence 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 all disputes, claims, or controversies arising out of or relating to this EOC 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 XVIII. Specific Authorization Agreeing to Mandatory Mediation and Arbitration Provision

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

2. 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.

3. Prominence 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 EOC, including any claim for benefits, statutory violation, breach of fiduciary duty, termination or partial termination, enforcement, interpretation, or validity of claims ("Covered Claims"), including the determination of the scope or applicability of this Mediation/ Arbitration Agreement.

4. References to Prominence includes our respective affiliates, agents, parents, subsidiaries, employees, predecessors-in-interest, successors and assigns under this EOC 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 Prominence on Your behalf. You agree that, by entering into this Mediation/Arbitration Agreement, You and Prominence 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 EOC.

Notice of a Dispute

1. 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 Prominence 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 Prominence and You do not reach an agreement to resolve the claim within 30 days after the Notice is received, You or Prominence 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 Prominence 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

1. 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 Prominence 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 based on 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 way 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, Prominence 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 PROMINENCE 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 PROMINENCE 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

1. The Parties agree that all disputes, claims, or controversies arising out of or relating to this EOC 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.

2. 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 Prominence 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 EOC 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 EOC 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.

3. In addition, notwithstanding any provision in this Mediation/Arbitration Agreement to the contrary, the Parties agree that if Prominence 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 Prominence 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.

Part XIX. Access to Care

Your Provider should give you an appointment for Medically Covered Services as described within this EOC for the type of visits below within specific timeframes. Please refer to the Provider Directory at ProminenceHealthPlan.com for contact information and locations:

Service	Appointment Type	Description/Instructions	Timeframes
Primary Care	Urgent Care	When you need non-emergent, non-life-threatening care related to Injury, Illness, or any other type of condition. • During business hours, call your PCP. • After business hours, visit an Urgent Care Center.	Within 24 hours
	Routine Care	Visits for non-urgent routine care.	Within 3 weeks
	Preventive, adult	Visits for periodic physical exams, Preventive Services (including screenings for cancer, diabetes, cholesterol, blood pressure, and others as recommended by the U.S. Preventive Services Task Force.	Within 3 months
	Preventive, children		Within 2 months
Specialty Care	Routine Care	Visits for non-urgent routine care	Within 30 calendar days
	Urgent Care	When you need non-emergent, non-life-threatening care related to Injury, Illness, or another type of condition. • During business hours, call your specialist. • After business hours, visit an Urgent Care Center.	Within 24 hours
Behavioral Health Services	Routine	Visits for non-urgent routine care.	Within 14 calendar days
	Urgent care	When you need non-emergent, non-life-threatening care related to Injury, Illness, or another type of condition. During and after normal business hours, call yourbehavioral health specialist.	Within 48 hours
	Follow-up care	Call your behavioral health specialist.	Within 30 calendar days
	Non-life-threatening emergent care	An Emergency where clinical evidence showsthat a person requires immediate care, but that lack ofcare would not lead to death. Call your behavioral health specialist.	Within 6 hours
Prenatal Care	1st and 2nd trimester	Care for women in their 1st and 2nd trimester, call your OB/GYN Provider	Within 7 calendar days
	3rd trimester	Care for women in their 3rd trimester, call your OB/GYN Provider	Within 3 calendar days
Emergency Care	N/A	An Emergency medical condition that is very seriousand could be life threatening. If you believe you have an Emergency, call 911 or go tothe nearest Emergency room (ER). If you are not sure if you need to go to the ER, call your primary care Provider or Teladoc at (800)TELADOC or teladoc.com.	Available 24/7
After-hours Care	N/A	Call your PCP. Even if the office is closed, your PCP willhave a 24-hour answering service. Leave a message and someone will call you back to tell you what to do. You may also contact Teladoc at (800)TELADOC or teladoc.com.	Available 24/7
Hospital Care	N/A	Coverage is provided for Medically Necessary CoveredServices and must be coordinated by an In-Network Provider.	N/A

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