Prominence℠
HealthFirst

Prominence HealthFirst Evidence of Coverage

YOUR INDIVIDUAL EVIDENCE OF COVERAGE

This is Your Individual Evidence of Coverage (EOC) with Prominence HealthFirst (herein referred to as "Prominence HealthFirst"), 1510 Meadow Wood Lane, Reno, Nevada, 89502, 775.770.9310.

This EOC is provided to each Subscriber who has enrolled in Prominence HealthFirst. The EOC, Summary of Benefits (SOB), Your enrollment form and identification card become the contract between You and Prominence HealthFirst. By enrolling in Prominence HealthFirst 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 HealthFirst. Please keep these materials handy so You can refer to them for information about Your Health Plan coverage.

Prominence HealthFirst is a Health Maintenance Organization (HMO) and all healthcare services must be coordinated by an In-Network Practitioner/Provider. Certain services may require Prior Authorization by Prominence HealthFirst through an In-Network Practitioner/Provider except for Emergency Care.

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

If You have questions about this EOC, please call a Prominence HealthFirst Member Services Representative at 775.770.9310 or 800.863.7515 or for (TTY Operator Assistance) 800.326.6868. Our website, www.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.

Division of Insurance
1818 E. College Pkwy., Suite 103
Carson City, Nevada 89706
775.687.0700 or 888.872.3234
Monday – Friday, 8 a.m. – 5 p.m.

Las Vegas State of Nevada
Division of Insurance
2501 East Sahara Ave., Suite 302
Las Vegas, Nevada 89104
775.486.4009 or 888.872.3234
Monday – Friday, 8 a.m. – 5 p.m.

151214 FNL AUG2015

Online Member Benefit Information

This information sheet is designed to provide Prominence Health Plan Members with step-by-step directions about how to create a login and password to access secure online Member benefit information. The Health Information Portability and Accountability Act of 1996 ("HIPAA") protects patient privacy. This online benefit information service is HIPAA compliant.

SYSTEM FEATURES

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

CURRENT MEMBERS

To access the secure online Member portal, visit www.prominencehealthplan.com > Health Plan Members > Secure Online Member Portal.

If You have forgotten Your password, select "Forgot Username or Password?" and follow the screen prompts.

NEW USER REGISTRATION

Before You begin, You will need Your Health Plan ID number located on Your identification card.

- Visit www.prominencehealthplan.com> User Login > Member Login.
- Select "Create an Account"
- Secure online member portal link
- Access your plan benefits
- Create an Account and complete the process

Once the log-in process has verified, your demographics, log-in 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 Health Plan Member Service
775.770.9310 or 800.863.7515
Monday through Friday, 8 a.m. to 5 p.m.

Table of Contents

Abbreviations Key

ADEA - Age Discrimination in Employment Act

APTC - Advanced Payments of the Premium Tax Credit

COB - Coordination of Benefits

COE - Center of Excellence

CSR - Cost Sharing Reduction

DME - Durable Medical Equipment

EME - Eligible Medical Expense

EOC - Evidence of Coverage

ERISA - Employment Retirement Income Security Act

ESRD - End Stage Renal Disease

FDA - U.S. Food and Drug Administration

FPL - Federal Poverty Level

HMO - Health Maintenance Organization

IPA - Independent Practice Association

NCQA - National Committee for Quality Assurance

OCHA - Office of Consumer Health Assistance

PCP - Primary Care Practitioner

PDL - Preferred Drug List

PHSA - Public Health Services Act

POS - Point of Service

QI - Quality Improvement

SOB - Summary of Benefits

TMJ - Temporomandibular Joint Disorder

TPN - Total Parenteral Nutrition

UM - Utilization Management

Para obtener asistencia en Español, llame al: ***775.770.9310 / 800.863.7515****. Los avisos están también disponibles en Español a petición.*

Part 1. Definitions

1. **Accessibility** - The extent to which a Member of an HMO 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 which 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. **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.
4. **Acute** - An illness or injury of short duration and generally of sudden onset and infrequent occurrence.
5. **Adverse Benefit Determination** - An Adverse Benefit Determination eligible for "internal" claims and appeals process 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 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 a coverage document regarding copays, deductibles, or other cost sharing requirements
6. **Alternative Medicine** - Approaches to medical diagnostic and therapy that have not been developed by use of generally accepted scientific methods. Forms of Alternative Medicine include acupressure, Acupuncture, aroma therapy, ayurveda, biofeedback, herbal medicine, holistic medicine, homeopathy and hypnosis.
7. **Anniversary or Anniversary Date** - The 12-month contractual period upon which the coverage under this EOC renews.
8. **Anorexia Nervosa** - A medical condition characterized by a refusal to maintain a minimally normal body weight.
9. **Appeal** - A written request to Prominence HealthFirst to change an Adverse Benefit Determination.
10. **Authorization** - The process by which an In-Network Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Medical Plan Member and obtain approval from the Medical Plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment; payment is dependent upon eligibility at the time Covered Services are received.
11. **Authorized Representative** - A person to whom a covered person has given (a) express written consent to represent the covered person in an external review of an adverse determination; (b) person authorized by law to provide substituted consent for a covered person; or (c) family member of a covered person or the covered person's treating provider only when the covered person is unable to provide consent.
12. **Autism Spectrum Disorder** - Is a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.
13. **Availability** - The extent to which the Medical Plan has Practitioners/Providers of the appropriate type and number distributed geographically to meet the needs of its membership.
14. **Bariatric Restrictive Services** - Includes various surgical interventions to accomplish weight-loss reduction in individuals who meet the criteria.
15. **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.
16. **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.

17. **Calendar Year** - The 12-month period beginning January 1 and ending December 31.
18. **Cardiac Rehabilitation Services** - Phase I and Phase II includes inpatient cardiac monitored services; programs are Practitioner ordered and supervised.
19. **Centers of Excellence (COE)**

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

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

    For more information about the COE program and all participating facilities, please visit www.prominencehealthplan.com > Health Plan Members > View Provider Directories > Centers of Excellence.
20. **Chelation Therapy** - The treatment and removal of lead poisoning or other heavy metal poisoning from the body.
21. **Children Under the Age of 26** - The Affordable Care Act (ACA) requires that dependent children be covered up to age 26.
22. **Chronic/Supportive** - An illness or injury that is, or is 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.
23. **Coinsurance** - The percentage of charges billed or the percentage of Eligible Medical Expense charges, whichever is less, that a Member must pay a Practitioner/Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the Practitioner/Provider who bills for the Covered Services.
24. **Complaint** - An oral or written expression of dissatisfaction from a Member or Practitioner/Provider.
25. **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 Aortagraphy, Complex Musculoskeletal imaging and SPECT scans. This category of imaging does not include screening and diagnostic mammography, x-ray, ultrasound, MRI and CT scans, and basic diagnostic testing.
26. **Compression Stockings** - Various graded stretch material to create compression.
27. **Congenital** - Existing at or dating from birth or acquired during development in the uterus.
28. **Contraceptive Methods** - All Food and Drug Administration (FDA) approved contraceptive methods prescribed by a woman's doctor are covered.
29. **Coordination of Benefits (COB)** - A process by which another health plan (if the Member is enrolled on both this Prominence HealthFirst Plan and another health plan) may be responsible for claims payment either as the primary or secondary carrier.
30. **Copayment** - The amount paid by You directly to the healthcare Practitioner/Provider at the time the services are received. These Copayments are described in the SOB, a separate document, which is supplied to the Subscriber.
31. **Cosmetic** - Procedures which are performed primarily to improve or change physical appearance or bodily form, but which do not correct or materially improve a physiological function.

32. **Covered Services** - Those Medically Necessary medical and Hospital services described in this EOC which 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.

33. **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.

34. **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.

35. **Deductible** - A set amount of covered charges occurring each calendar year which must be paid by the Member before benefits are payable under this Plan. Copays do not count towards the deductible; copays do count towards the out-of-pocket maximum.

36. **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.

37. **Dependent** - Any Member of the Subscriber's family who meets the eligibility for coverage as this EOC and has been enrolled by the Subscriber.

38. **Developmental Delay** - 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.

39. **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 Practitioners to detect disease earlier, make diagnoses, prescribe therapies, and monitor results. Some diagnostic testing is considered Complex Diagnostic Testing.

40. **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.

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

42. **Durable Medical Equipment (DME)** - Equipment health plans determines to be:

    a. Designed and able to withstand repeated use;

    b. Used primarily and customarily for a medical purpose;

    c. Generally not useful to a Member in the absence of an illness or injury; and

    d. Suitable for use in the home.

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

44. **Emergency Services** - The Prominence HealthFirst Emergency Services are provided as follows:

    a. Without a Prior Authorization requirement, even for Out-of-Network services;

b. Without regard to whether the provider of the services is In-Network;

c. 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

d. 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.

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

46. **Evidence of Coverage (EOC)** - This document, any Riders, the SOB, and any amendments that may be added in the future which explain the services and benefits covered by Prominence HealthFirst and defines the rights and responsibilities of the Member and Prominence HealthFirst.

47. **Exclusion** - Any item or service that is not a Covered Service under this EOC.

48. **Experimental/Investigational** - A drug, device, medical treatment or procedure that in Prominence HealthFirst'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;

    d. Unless otherwise mandated by State and Federal Statutes.

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

50. **Grace Period** - For individuals not eligible to receive APTC, the 30-day period from the date Premium payment is due until it is considered delinquent. For an individual eligible to receive APTC, the 3-month period from the date premium payment is due. Claims may be pended until payment is received. During the Grace Period, coverage remains in effect.

51. **Habilitative Services** - Healthcare 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.

52. **Healthcare.gov** - Is a health insurance exchange website operated under the United States federal government under the provisions of the Patient and Protection and Affordable Care Act, that allows You to do comparison shopping for health insurance.

53. **Health Information** - 24-Hour NurseLine - Members have free access to our Health Information/24-hour NurseLine. They can call about health related problems, accidents, or to ask health-related questions.

    The NurseLine team is staffed with experienced health specialists and registered nurses who are able to assist Members in determining the safest, most appropriate level of care, including self-care options and next steps. Member ID cards should be accessible when placing a call to the NurseLine, as Plan Membership will need to be verified by the NurseLine staff during the call. Members can call the NurseLine toll free at 800.243.5495.

54. **Health Plan** - Prominence HealthFirst, a Health Maintenance Organization (HMO), organized and operating pursuant to Chapter 695C, Nevada Revised Statutes, any amendments thereto and all other applicable provisions of the laws of the State of Nevada.

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

56. **Hospital** - An Acute Care Hospital licensed by the State and approved by the Joint Commission on Accreditation of Healthcare 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.

57. **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.

58. **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.

59. **Independent Physicians Association (IPA)** - An association that brings Primary Care Physicians, Specialists, and ancillary providers together to participate as Members of an organization that provides contracts for healthcare services to Prominence HealthFirst.

60. **In-Network** - A term for providers or facilities that enter into a network agreement with Prominence HealthFirst.

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

62. **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 HealthFirst.

63. **Medical Director** - A Physician designated by Prominence HealthFirst to monitor appropriate utilization of healthcare services and quality of care.

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

    a. Catheter and catheter supplies - Foley catheters, drainage bags, irrigation trays;

    b. Colostomy bags (and other ostomy supplies);

    c. Dressing/wound care-sterile dressings, ace bandages, sterile gauze and topers, 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.

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

    a. In accordance with Generally Accepted Standards of Medical Practice.

    b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your sickness, injury, mental illness, substance use disorder, disease or its symptoms; and;

    c. Not mainly for Your convenience or that of Your doctor or other healthcare provider.

    d. Not more costly than an alternative drug, services(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your sickness, injury, disease or symptoms.

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

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether healthcare 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.

66. **Member** - Any Subscriber or eligible enrolled Dependents entitled to benefits under this EOC.

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

    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.

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

68. **Non-Covered Services** - Those services excluded from coverage pursuant to this EOC.

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

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

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

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

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

71. **Oral Chemotherapy** – Coverage for orally administered chemotherapy for the treatment of cancer. Prominence HealthFirst 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.

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

73. **Out-of-Area Services** - Those Medically Necessary Covered Services provided outside of the Prominence HealthFirst Service Area and are limited to Emergency Services or Urgent Care services only. All other services outside the Service Area must be determined to be Medically Necessary and Prior Authorized by Prominence HealthFirst.

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

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

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

77. **Premium** - The periodic payment, usually monthly, made to Prominence HealthFirst by You, or on Your behalf, that entitles You to the benefits outlined in this Evidence of Coverage.

78. **Preventive Care Services** - Preventive Care Services including: periodic physical exams, preventive health services (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing, vision, immunizations, health education and intervention services, and HIV testing), and additional preventive care for women as recommended by the U.S. Preventive Services Task Force. This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law - see the list for the state Preventive Health Guidelines at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventative-Care.

79. **Primary Care Practitioner (PCP)** - A General Family Practitioner, Internist or Pediatrician or a mid-level Practitioner who is chosen by You from the Prominence HealthFirst Provider Directory. Each Member must choose a Primary Care Practitioner a mid-level Practitioner, a Licensed Medical Practitioner such as a Advanced Practical Nurse (APN), Nurse Practitioner (NP) or Physician Assistant (PA) who is responsible to provide, arrange and coordinate all of the healthcare services provided by this EOC to assure continuity of care for You and initiate any elective Referrals and Prior Authorizations for specialized care You may require. For children, a Member may designate a pediatrician as the primary care provider.

80. **Prior Authorization** - The process in which an In-Network Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Member and obtain approval from the Plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment: payment is dependent upon eligibility at the time Covered Service is received. For a complete list of services requiring an authorization visit our website at www.prominencehealthplan.com. A Member does not need Prior Authorization from the Medical Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional who specialize in obstetrics or gynecology. The Healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact Prominence HealthFirst Member Services at 775. 770.9310 or 800.863.7515, or www.prominencehealthplan.com.

81. **Professional Services** - Those Covered Services, except as excluded or limited in this Evidence of Coverage, performed by Practitioners and health professionals which are Medically Necessary and generally recognized as appropriate care within the Service Area and in accordance with Prominence HealthFirst policies and procedures.

82. **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.

83. **Provider Directory** - Is a list of Prominence HealthFirst's In-Network Practitioners/Providers who provide Medically Necessary Covered Services to all Members. The Provider Directory can be acquired upon enrollment, upon renewal, upon request and at www.prominencehealthplan.com. The Provider Directory is available through Healthcare.gov at the time of enrollment to assist Members with their selection of providers for their healthcare services. As a Member of Prominence HealthFirst, any services You receive must be obtained from an In-Network Practitioner and/or Provider. Additions and changes are continuously made to the Provider Directory; therefore, to confirm a Practitioner or Provider's

participation with Prominence HealthFirst, contact Member Services at 775.770.9310 or 800.863.7515 prior to receiving services. It should be noted that the Provider Directory represents a list of Practitioners which Prominence HealthFirst has a contractual relationship for the provision of medical services, but this list does not imply an employer/employee relationship between Prominence HealthFirst and the Practitioners.

84. **Refraction** - The act of determining the nature and degree of the refractive errors in the eye and correction of the same by lenses.
85. **Rehabilitative Therapy** - Physical, speech, occupational, cardiac and pulmonary/respiratory therapy.
86. **Rescissions** – Prominence HealthFirst will not terminate or rescind coverage once a Member is enrolled unless the Member (or person seeking coverage on behalf of the individual) performs an intentional act, practice or omission that constitutes fraud, or unless the individual makes an intentional material misrepresentation of fact as prohibited by the terms of the EOC. The Plan will provide at least 30 days advance written notice to each Member who would be affected before Plan coverage will be rescinded.
87. **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 on-site housing/dormitory accommodations, and on-site day treatment programs.
88. **Respite Care** - Is the short-term, temporary relief to those who are caring for family Members.
89. **Secondary** - Primary Care Practitioner (PCP) - A Plan Obstetrician/Gynecologist (OB/GYN) selected by a female Member as a Secondary Primary Care Practitioner (PCP) for female-related conditions. This does not replace Your Primary Care Practitioner's responsibilities related to Your total healthcare.
90. **Self-Directed** - Those Services a Member elects to Self-Direct to an Out-of-Network Practitioner or to a Specialist.
91. **Self-injectables** - Any medication that can be given by the sub-cutaneous or intra-muscular route (excluding insulin) is considered a self-injectable. Self-injectable does not refer to the fact that the medication is given by a Member to him/herself, but rather that the route of injection is not intravenous and does not normally, require a specialized setting and/or extensive medical surveillance.
92. **Service Area** - The area which Prominence HealthFirst is approved by the State of Nevada to service.
93. **Short Term Therapy** - Is limited to treatment for conditions which are subject to significant clinical improvement within the period of time defined in this EOC.
94. **Skilled Nursing Care** - Services that can only be performed by, or under the supervision of, licensed nursing personnel.
95. **Skilled Nursing Facility (SNF)** - A facility which is licensed by the State of Nevada to provide inpatient medical and nursing care, is recognized as such by Medicare and has a contract with Prominence HealthFirst. 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.
96. **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.
97. **Specialist** - A physician other than a Primary Care Physician who is participating in Prominence HealthFirst and listed in the current Provider Directory. A Specialist should only be seen when coordinated by an In-Network Practitioner/Provider and Prior Authorized by Prominence HealthFirst except in the case of Emergency Services.
98. **Specialty Drugs** - Includes self-injectables and medications given by other routes of administration. Specialty Drugs require the coinsurance listed on the your Summary of Benefits (SOB). Self-Injectables include combination therapy kits, which can be obtained from an outpatient pharmacy, and can be self-administered. Insulin is not considered a Specialty Drug. This list of special pharmaceuticals can be found on the Prominence Health Plan website. Contact Member Services for more information.

99. **Specialty Pharmacy** - Some Specialty Drugs require the member to obtain the drug through the Prominence HealthFirst Specialty Drug provider. Contact Member Services for more information.
100. **Subscriber** - A person who meets all eligibility requirements and has completed an enrollment form and has paid, or has had paid on his/her behalf, all applicable Premiums. The Subscriber is the person to whom this Evidence of Coverage is issued.
101. **Summary of Benefits (SOB)** - The summary of Covered Services, benefit limitations, Coinsurance (if applicable) and Deductibles (if applicable) that is provided to the Member.
102. **Supplemental Riders** - Additional or expanded benefits which are subject to applicable underwriting requirements and Premium rates. Such Riders will be included with and become a part of this EOC.
103. **Telehealth** - A delivery of healthcare services from a provider of healthcare to a patient at a different location through the use of technology that transfers information electronically, telephonically or by fiber optics, not including standard telephone, facsimile or electronic mail. The Provider must hold a valid license or certificate to practice his or her profession in this State.
104. **Total Parenteral Nutrition (TPN)** - The delivery of nutrients through an intravenous line directly into the blood stream.
105. **Urgent Care Services** - Care for Medically Necessary Covered Services due to injury, illness or another type of condition, usually not life-threatening, which should be treated within 24 hours. Routine or follow-up care is not considered an Urgent Care Service.
106. **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.
107. **We or Us** - Refers to Prominence HealthFirst.
108. **You or Your** - refers to You, Subscriber/Member and Your eligible enrolled Dependents (Members).

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

1. **Guidance on Choosing Your Primary Care Practitioner (PCP)** - Medical Plan Members have the right to designate any PCP who is a Participating Provider and who is available to accept You or Your eligible enrolled Dependent Members. Until You make this designation, the Medical Plan will designate one for You. For information about how to select a PCP, and for a list of the participating PCP, contact Prominence HealthFirst Member Services at 775.770.9310 and 800.863.7515.

2. **Access to Obstetrical or Gynecological Care** - A Medical Plan Member does not need Prior Authorization from Prominence HealthFirst or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact Prominence HealthFirst Member Services at 775.770.9310 and 800.863.7515.

3. **Guidance on Dependent Coverage to Age 26** - Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan.

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

5. **Coverage of Preventive Health Services** - The Plan provides preventive services such as mammograms, colonoscopies, cancer screenings, blood pressure and cholesterol tests, counseling to lose weight or quit smoking, health check-ups, and immunizations for children without cost-sharing by Members. Preventive Health Services provided without cost-sharing include:

   a. Services recommended by the US Preventive Services Task Force;

   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;

   c. Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration; and

   d. Preventive care and screenings for women supported by the Health Resources and Services Administration.

6. **Prohibition On Discrimination In Favor Of Highly Compensated Individuals** - The Plan prohibits discrimination in favor of highly compensated individuals as to plan eligibility or plan benefits.

Part III. Advance Directives: Making Your Healthcare Wishes Known

Prominence HealthFirst 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. As long as You can speak for Yourself, Prominence HealthFirst Providers will honor Your wishes. If You become so sick that You cannot speak for Yourself, then this advance directive will guide Your healthcare providers in treating You and will save Your family, friends and Practitioners from having to determine what You would have wanted.

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

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

You can purchase forms from an office supply store or request a form from Your PCP or they are also available on our secure Member website at www.prominencehealthplan.com. They are available in English and Spanish. Alternatively, You may wish to speak with Your attorney.

You should provide copies of Your completed directive to:

1. Your PCP;
2. the person designated as Your agent for making healthcare decisions; and
3. Your family.

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

If You believe Your contracted practitioner/provider has not complied with Your advance directive, You may file a Complaint with the State of Nevada Health Division.

Part IV. Utilization Management and Quality Improvement Programs

1. HEALTH SERVICES 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 Plan Medical Director. Utilization Management review decisions are based only on appropriateness of care, services requested and existence of benefit coverage. Prominence HealthFirst does not incentivize Practitioners/Providers or other individuals conducting utilization review for denials of coverage or service, nor does it provide financial incentives to those reviewing the cases to encourage denial determinations. Utilization Management staff provides telephonic coverage from 8 a.m. through 5 p.m. (normal business hours) Monday through 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. Utilization Management provides confidential voice mail 24 hours a day, seven days a week at 775.770.9247 and a confidential fax 24 hours a day, seven days a week at 775.770.9364. Referrals are not needed for specialty care by the plan.

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 in and outpatient services. Requests for services requiring Prior Authorization are reviewed and determinations made by the appropriately licensed Health Services personnel. For a complete list of Prior-authorization requirements, please visit www.prominencehealthplan.com/members.

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 care, rehabilitation, skilled nursing and behavioral health facilities) and care provided by home health agencies as needed. Discharge Planning is provided to assist patients with needs outside the healthcare facility setting. Care Coordination is a collaborative process, which coordinates and evaluates the options and services to meet an individuals health needs. Complex Utilization Management is a systemic assessment of care and services to Members with complex needs. Assistance with care transitions is provided through the plans inpatient discharge call campaign, which provides the PCP with patient encounter information after discharge. Care Coordination/ Utilization Management will assist in the process of identifying Members who may benefit from Population/Disease Management or - Complex Utilization Management for those Members with multiple complex medical conditions. Utilization Management can provide assistance in assuring continuity and coordination of care by providing assistance with referrals to appropriate contracted Centers of Excellence, tertiary and transplant care.

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

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

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

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

Contacting Health Services: If You have any questions or wish to make a referral to Care Coordination/ Utilization Management, please call our Central Intake line at 775.770.9350, Monday-Friday, excluding holidays.

2. CARE COORDINATION SERVICES, GENERAL CARE COORDINATION AND DISEASE MANAGEMENT

Care Coordination can assist Members whose benefits are ending by providing alternatives and resources for continuing care and how to obtain it as appropriate. Care Coordinators can assist pregnant adolescents in their transition from Pediatrics to an Adult Primary Care Practitioner, OB/GYN, Family Practitioner or Interventionist. Care Coordinators can also assist those Members reaching adulthood and have not chosen an Adult Primary Care Physician and helping them select an Adult Primary Care Practitioner.

3. QUALITY IMPROVEMENT PROGRAM

Prominence HealthFirst Quality Improvement (QI) Program is designed to assess and improve the quality of care and service delivered to Medical Plan Members. The goal of the QI Program is to monitor the quality and appropriateness of patient care and service and to meet or exceed established local, State and national standards. Methods to achieve this include, but are not limited to, establishing standards and performance goals for the delivery of care and services, measuring performance outcomes and development and implementation of action plans to improve outcomes. The focus of the QI Program is to improve the overall health status of Plan 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 health plan's Organizational Structure and the Quality Improvement Committee and subcommittee structures to promote appropriate system development and implementation to meet the requirements of Members, employers, employees and the In-Network Practitioner/Provider network.

Additional information regarding the Utilization Management and/or the Quality Improvement programs is available by accessing Prominence HealthFirst website at www.prominencehealthplan.com or by calling Member Services at 775.770.9310 or 800.863.7515.

4. AFFIRMATIVE STATEMENT REGARDING INCENTIVES

Prominence HealthFirst distributes annually An Affirmative Statement about Incentives to all employees, practitioners and providers affirming the following:

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

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

Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Incentives, including compensation, for any person are not based on the quantity or type of denial decisions rendered.

Part V. Eligibility, Enrollment and Effective Date of Coverage

1. ELIGIBILITY

A qualified individual may enroll in this plan through Healthcare.gov. Healthcare.gov follows enrollment rules specified by the Federal Government and the State of Nevada. If You enroll in this plan through Healthcare.gov, You may be eligible for tax credits to help pay for Your cost of coverage.

a. Eligibility To Enroll In A Qualified Health Plan 45 CFR § 155.305(A)

b. To be eligible to enroll in this plan through Healthcare.gov:

i. You must be a United State citizen or national or must be lawfully present in the United States;

ii. You cannot be incarcerated (in prison; does not apply if You are awaiting disposition of charges); and

iii. You must be a resident of the State of Nevada.

c. Eligible Dependents

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

i. Be the Subscriber's legal spouse;

ii. Hold a Certificate of Registered Domestic Partnership; Be the Subscriber's Domestic Partner.

Coverage is extended to an adult who has chosen to share one another's lives in an intimate and committed relationship of mutual caring. The domestic partnership must be established in the State of Nevada by filing a form prescribed by the Secretary of State, a signed and notarized statement declaring that both persons have chosen to share one another's lives in an intimate and committed relationship of mutual caring and desire of their own free will to enter into a domestic partnership and paying all required fees and costs with the Secretary of State. All of the following requirements must also be met:

01. Both persons must be at least 18 years of age

02. Have not terminated that domestic partnership

03. Both persons are competent to consent to the domestic partnership

04. Both persons are not related by blood in a way that would prevent them from being married to each other in the State of Nevada

05. Neither person is married or a Member of another domestic partnership

06. Both persons share a common residence; and

07. The couple shall have a Certificate of Registered Domestic Partnership issued by the Secretary of State. Except as otherwise provided in NRS 122A.120:

08. Domestic Partners and former Domestic Partners have the same rights, protections and benefits, and are subject to the same responsibilities, obligations and duties under law, whether derived from statutes, administrative regulations, court rules, government policies, common law or any other provisions or sources of law, as are granted to and imposed upon former spouses, in the case of domestic partners and former spouses, and in the case of former domestic partners.

09. A surviving domestic partner, following the death of the other partner, has the same rights, protections and benefits, and is subject to the same responsibilities, obligations and duties under law, whether derived from statutes, administrative regulations, court rules, government policies, common law or any other provisions or sources of law, as are granted.

iii. Be a Member's child under the age of 26. The term child includes natural children, step-children, eligible foster children, and children for whom You have been appointed by the court as permanent legal guardian, or children who have been legally adopted or are awaiting finalization of adoption by You; and

iv. Be an unmarried child who is and continues to be both (1) medically certified as mentally or physically disabled and (2) dependent upon the Subscriber of the insured for support and maintenance. This condition must have occurred before the child reaches age 19. Proof of this incapacity must be furnished to Prominence HealthFirst within 31 days after such Dependent attains age 19 and then once a year beginning two years after the Dependent has reached the age of 19.

Prominence HealthFirst will require a completed Dependent Disability Verification form, provided by Prominence HealthFirst, and evidence that the dependent is declared to be financial dependent on the Subscriber's tax documents.

d. Eligibilty For Advanced Payment Of The Premium Tax Credit (APTC) 45 CFR § 155.305(F) and Cost Sharing Reduction (CSR) 45 CFR § 155.305(G)

i. A key feature of the Affordable Care Act is the introduction of Advance Payments of the Premium Tax Credit (APTC). These are payments made monthly on Your behalf by the Federal government directly to the selected insurance carrier thereby decreasing Your monthly premium payment. It should be noted that You will need to reconcile these credits when You file Your taxes with the IRS at the end of the year.

You are generally eligible for the APTC if You:

01. Enroll in this plan through Healthcare.gov;
02. Expect to have a household income below 400% of the Federal Poverty Level (FPL) during the plan year;
03. Are not eligible for Medicare Part A, Medicaid or other minimum essential coverage; and
04. Attest that, for the plan year:

You will file an income tax return;

01. You will file a joint tax return (only applies if You are married);
02. No other taxpayer will be able to claim You as a tax dependent; and
03. You will claim a personal exemption deduction on Your tax return for the members of Your family, including You and Your spouse.
04. Eligibility for APTC is determined by Healthcare.gov at time of enrollment.

ii. Another feature of the Affordable Care Act is Cost Sharing Reductions (CSR). CSRs decrease the overall out-of-pocket costs (deductible, coinsurance, copayment, and out-of-pocket maximum) for eligible individuals. You may be eligible for CSRs if:

01. You are eligible for APTC;
02. Your household income is not more than 250% of Federal Poverty Level (FPL); and
03. You are enrolled in any Silver Plan in the Individual Market through Healthcare.gov.

iii. Healthcare.gov will periodically examine available data sources (IRS, SSA, HHS, DHS, etc.) to identify deaths and eligibility determinations for Medicare, Medicaid, CHIP and coverage under other employer sponsored or other group plans, as coverage under these programs may make You ineligible for APTC and Cost Sharing Reduction (CSR). If Healthcare.gov receives updated data related to income, family size, or family composition, or any other factor impacting eligibility, Healthcare.gov will provide You with a notice that will include the updated information, as well as Your projected eligibility determination after considering the information. You will have 30 days from the receipt of the notice to notify Healthcare.gov that the information is inaccurate. If You do not respond within the 30-day period, Healthcare.gov will proceed with the changes in eligibility that results from the new information.

iv. The effective date of the new eligibility determination will be the first day of the month following the date of the notice of a change in eligibility if that notice was received between the first and fifteenth of the month, and the first day of the second month following the date of the notice if that notice was received between the sixteenth and the end of the month.

v. If You are employed and Healthcare.gov has determined that You are eligible for APTC, Your employer will be notified of the eligibility determination. The notification will indicate that You have been determined eligible for APTC, that Your employer may have to pay a penalty for not providing health insurance coverage and will provide Your employer information regarding how to appeal the determination.

vi. You or Your Authorized Representative (broker, navigator, enrollment assister, etc.), if You assign one, may submit a notification of a change in eligibility information through the web portal, email, phone, fax, or regular mail. Healthcare.gov will process and verify the information to determine the impact to eligibility for QHP enrollment, APTC and CSR.

e. Annual Eligibilty Redetermination 45 CFR § 155.335

Healthcare.gov requires all individuals to participate in open enrollment and undergo an annual eligibility redetermination every year. Prior to open enrollment, Healthcare.gov will provide You an annual redetermination notice that includes the following information:

i. Updated household income and family size information (if any was identified through external data sources).

ii. The data used in the enrollee's most recent eligibility determination.

iii. The enrollee's projected eligibility determination for the following year, after considering any updated information including, if applicable, the amount of any advance payments of the premium tax credit and the level of any cost-sharing reductions.

You must report any changes in response to the information included in the annual redetermination notice within 30 days from the date of the notice. You may report these changes through any available medium including through the web portal, email, phone, fax, or regular mail. The information will be verified by Healthcare.gov and the coverage based on the redetermination and Your updated plan selections will be effective January 1 following open enrollment.

If You remain eligible for coverage in this plan upon annual redetermination, but fail to select a plan during open enrollment, You will remain covered under this plan and Your premium will be adjusted based on the new cost of this plan until You terminate coverage or You are terminated for another reason such as non-payment of premium.

f. Right to Appeal 45 CFR § 155.355

i. All notices sent during the eligibility determination, inconsistency resolution, and renewal processes described above will include a notice of the right to appeal along with instructions on how to file an appeal for any eligibility determination.

ii. The process for filing an appeal with Healthcare.gov for any eligibility determination is as follows:

01. If You would like to file a formal appeal, You may notify the Healthcare.gov Customer Contact Center through email, phone, fax, or regular mail, or the web portal. https://healthcare.gov/marketplace-appeals.

02. A Healthcare.gov customer service representative will review the facts of the appeal request and determine if sufficient information has been provided to proceed with the appeals process. If more information is required, the customer service representative will contact You and request that You provide the needed information.

03. Once the required information has been gathered, an Eligibility Case Worker will review the facts of the case and the supporting documentation. If the facts of the case warrant it, the Eligibility Case Worker will make the requested change and send a new notice of eligibility determination to You.

04. If the facts of the case do not support a change in the eligibility decision and You still disagree with the determination, the case will be escalated to a level two appeal to be heard by a Hearing Officer of Healthcare.gov. You will be notified when You should appear to have Your

appeal heard by the Hearing Officer.

05. The Hearing Officer will hear the facts of the case, and You will have the opportunity to explain Your situation to the Hearing Officer. A final determination on the appeal will be made once all of the facts of the case have been heard and understood and a letter of eligibility determination will be provided to You following the appeal.

06. If the facts of the case warrant it, the Hearing Officer will notify the Customer Contact Center to reverse the determination and send a new notice of eligibility determination to You.

07. If the facts of the case do not support a change in the eligibility decision and You still disagree with the determination, You may appeal the decision to the U.S. Department of Health and Human Services.

Specific instructions and deadlines will be provided with each communication regarding the appeal process. If you fail to follow the instructions or do not provide the necessary information by the deadlines provided, the eligibility decision will be final.

g. Special Eligibilty Standards And Process For Indians 45 CFR § 155.350 If You are a verified American Indian or Alaskan Native, You are permitted to change Your QHP selection a maximum of once every 30 days. Healthcare.gov will check Your tribal status against available federal data sources or a roster of tribe members from an authorized representative of Your federally recognized tribe, if provided. If Healthcare.gov cannot verify Your status as a tribe member, You may be required to provide other proof of tribal status. Please note that if You change to a plan with another carrier, all of Your plan accumulators such as deductibles and out of pocket maximums will be reset under the new plan.

Additionally, if You are an American Indian or Alaskan Native, You may be eligible for no cost sharing plan; You will not pay deductibles, coinsurance, copayments or out of pocket maximums. To qualify for these special cost sharing reductions:

i. You must be eligible for Advance Payments of the Premium Tax Credit (APTC);

ii. Your household income must be no more than 300 percent of the Federal Poverty Level (FPL); and

iii. You must be enrolled in a plan in the individual market through Healthcare.gov.

Further, the Affordable Care Act directs a QHP issuer to eliminate cost sharing for an Indian, regardless of household income, for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, and prohibits the QHP issuer from reducing payments to any such entity for such items or services.

2. ENROLLMENT

a. Enrollment through www.healthcare.gov.

A qualified individual may enroll in this plan through Healthcare.gov which follows enrollment rules specified by the Federal Government and the State of Nevada. These enrollment rules may or may not apply if You enroll in this plan directly with the insurer. If You enroll in this plan through Healthcare.gov, You may be eligible for tax credits to help pay for Your cost of coverage. The following sections discuss the rules and benefits of enrollment through Healthcare.gov.

b. Annual Open Enrollment Periods 45 CFR § 155.410

Healthcare.gov provides an open enrollment period each year and You may enroll in a QHP or change QHPs during open enrollment, if eligible.

You are only permitted to change QHPs during the initial open enrollment period, annual open enrollment period, or a special enrollment period for which You have been found eligible.

Healthcare.gov provides a written annual open enrollment notification each year. You may change Your QHP selection during the annual open enrollment period. If You do not make a QHP selection during a subsequent open enrollment, Healthcare.gov will automatically enroll You in Your current plan selection if You are still eligible for that plan.

i. For a plan selection completed on the 1st through the 15th of a month, the following month; and

ii. For a plan selection completed on the 16th through the last day of a month, the second following month.

c. Special Enrollment Periods 45 CFR § 155.420

Outside of the initial open enrollment period and the annual open enrollment periods, You may encounter a life event that makes You newly eligible for another plan, ineligible for Your current plan, or entitles You to add or delete from coverage a Member of Your household. These life events trigger a special enrollment period, in which You are permitted to change Your plan selection. The events listed in Figure 4 trigger a special enrollment period. You have 60 days from the date of a triggering event to complete a plan selection. "Plan selection" includes selecting a plan and providing the required documentation and payment, if applicable. Unless otherwise indicated in Figure 4, coverage is effective (standard coverage effective date)

Figure 4: Qualifying Events to Enroll / Change QHP

Event Type	Required Documents As Applicable for the Event	When Coverage Begins or Ends
Birth	Birth Certificate (Marriage/ Domestic Partnership Certificate required for children of spouse/DP)	Coverage begins on the date of the event.
Adoption or Placement of Adoption	Adoption Certificate or Court Order (Marriage/ Domestic Part-nership Certificate required for children of spouse/DP)	Premium payment, APTC and CSR, if applicable, begins: a. For a date of event on the 1st of the month, on the date of birth; b. For a date of event after the 1st of he month, on the 1st day of the following month.
Marriage/ Domestic Partnership	Marriage/ Domestic Partnership Certificate and Birth or Adoption Certificate(s) for New Dependent Child(ren)	Coverage begins on the date of the event. Premium payment, APTC and CSR, if applicable, begins: a. For a date of event on the 1st of the month, on the date of birth; b. For a date of event after the 1st of the month, on the 1st day of the following month.
Loss of Minimum Essential Coverage	HIPAA Certification	Coverage begins on the first day of the month following the date of the event.
Individual gains status as a Citizen, National, or Lawfully Present	Citizenship certificate, Certificate of non-citizen national status Written documentation from US Immigration and Citizenship Services, immigration court, showing status as "lawfully present."	Coverage begins on the first day of the month following the date of the event.
Unintentional, Inadvertent, or Erroneous Enrollment/ Non-Enrollment as a Result of Healthcare.gov or HHS	Notice of Decision of Appeal	Standard Coverage Effective Date
QHP Substantially Violates a Material Provision of the Contract	Notice of Decision of Appeal	Standard Coverage Effective Date
Newly Eligible/ Non-Eligible for APTC or Change in Eligibility for CSR	Income Documents (Pay stubs, W2, etc.) or proof of change of family size	Standard Coverage Effective Date
Employer-Sponsored Plan No Longer Affordable or Fails to Provide Minimum Value	Income Documents (Pay stubs, W2, etc.) and premium tables for the employer's least expensive employee-only plan	Standard Coverage Effective Date
Permanent Move and Gain Access to New QHPs	One or more of the following: Rental Agreement Mortgage Statement Utility Bill	Standard Coverage Effective Date
American Indian or Alaskan Native	Proof of tribal status in a federally recognized tribe.	Standard Coverage Effective Date
Other Exceptional Circumstances	Varies and determined by Healthcare.gov	Standard Coverage Effective Date

3. Effective Dates

If You purchase coverage through Healthcare.gov, they will use the following guidelines to establish Your effective dates of coverage:

i. The open enrollment period begins November 1, 2015 and extends through January 31, 2016.

During that period, generally, if You select a plan and remit payment to Prominence HealthFirst:

ii. On or before December 15, 2015, Your coverage effective date will be January 1, 2016;

iii. Between the first and the fifteenth day of any subsequent month your coverage starts the first day of the next month

iv. January 1, 2016 and March 15, 2016, Your coverage effective date will be the first day of the following month; and

v. Between the sixteenth and last day of the month Your coverage effective date will be the first day of the second following month.

vi. Certain special enrollment situations may result in a mid-plan-year eligibility redetermination that varies from the above open enrollment periods.

Part VI. The HMO Network

You are eligible to receive medical care and services from In-Network Practitioners/Providers including medical, surgical, diagnostic, therapeutic and preventive services provided in the Prominence HealthFirst Service Area. Covered Services must also be determined to be Medically Necessary. As a Member of a Health Maintenance Organization (HMO), You and Your Primary Care Practitioner (PCP) must work together to coordinate Your healthcare services.

Each Member shall select, or have selected on his/her behalf, a PCP. You must choose Your PCP by referring to the current Prominence HealthFirst Provider Directory. All of these services can be accessed on the Health Plans website www.prominencehealthplan.com. A Member may change his/her PCP at any time for any reason by contacting Prominence HealthFirst Member Services via the secure website at www.prominencehealthplan.com. You must be registered at www.prominencehealthplan.com or call 775.770.9310 or 800.863.7515.

It is the responsibility of each Prominence HealthFirst Member to provide Prominence HealthFirst with a change of Your mailing address within 31 days of such address change. Changes can be made by contacting Member Services or via the secure website or at www.prominencehealthplan.com.

Except for Emergency Services, ONLY covered services which are coordinated by an In-Network Practitioner/Provider, and/or Prior Authorized by Prominence HealthFirst and obtained from an In-Network Practitioner/Provider are Covered Services. Prominence HealthFirst may not cover services rendered to a Member if a Member consults and/or receives care from a Practitioner or health professional in or out of the Prominence HealthFirst Service Area without Prior Authorization by Prominence HealthFirst.

When Your PCP determines that it is Medically Necessary for You to see a Specialist for Covered Services, the PCP will contact the Prominence HealthFirst Utilization Management Services Department to identify In-Network Practitioners/Providers in that specialty. Requests for services requiring Prior Authorization are reviewed for determination by the UM Department. If additional services/visits are required, the Specialist will contact the Prominence HealthFirst Utilization Management Department. As a Member, it is Your responsibility to ensure that You seek care from a Prominence HealthFirst In-Network Practitioner/Provider.

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

Part VII. Services and Benefits

Copayments required for medically necessary covered services must be made to the In-Network Practitioner/Provider at the time services are received. Refer to the SOB for Your schedule of Copayments.

1. Allergy Care

a. Coverage is provided for allergy testing and evaluation.

b. Coverage is provided for the preparation of allergy serum when prepared by the PCP or a Prominence HealthFirst Specialty Practitioner.

c. Pediatric and adolescent nebulizers are covered for home and school.

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

a. Homeopathic treatment will be covered when provided by an In-Network Practitioner/Provider. Homeopathic treatment, Acupuncture and Integrated Medicine will be covered when Medically Necessary.

b. All herbal medications and/or over-the-counter products are not covered.

c. For coverage limitations, consult Your SOB and Prior Authorization list.

3. Ambulance Services

a. Medically necessary covered ambulance services are provided within the Service Area when arranged by an In-Network Practitioner/Provider or Prominence HealthFirst. Coverage is available when such services are required for an emergency that could severely impair Your health, or when arranged in advance by an In-Network Practitioner/Provider or by Prominence HealthFirst for the medical necessity of transporting You from one facility to another facility.

b. Emergency ambulance service is a Covered Service when the ambulance is ordered for an emergency that could jeopardize Your health. Ambulance service will be covered when ordered by an employer, school or public safety official, or when You are not in a position to refuse the service. This excludes ambulance services for work-related injuries or illness or Non-Covered Services even if determined to be Medically Necessary.

c. For coverage limitations, consult Your SOB.

4. Clinical Trial or Study:

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

a. Clinical trial or study must is approved by:

i. An agency of the National Institute of Health as set forth in 42 U.S.C. section 281(b);

ii. A cooperative group;

iii. The (FDA) as an avocation for a new investigational drug;

iv. The United States Department of Veterans Affairs; or

v. The United States Department of Defense.

5. Cochlear Implant and Hearing Aids

Prosthetic cochlear implant is covered only for children 12 and under with congenital postlingual, profound, bilateral deafness who receive limited or no benefit from hearing aids. Benefit is limited to one per Member per lifetime. Hearing aids required for the correction of a hearing impairment (a reduction

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

6. Contraception and Sterilization

a. Food and Drug Administration (FDA) approved oral contraceptive pharmaceuticals, Intrauterine device (IUD), Diaphragm and NuvaRing.

b. (FDA) approved contraception and contraceptive counseling.

c. (FDA) approved sterilization procedures - services, treatment and procedures to induce voluntary elective sterilization.

7. Dental Care Services

Dental care services permitted under the medical plan include:

a. Treatment for accidental 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 months of the date of a documented injury and may require a Prior Authorization by Prominence HealthFirst.

b. Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof or floor of the mouth.

c. Use of an outpatient or inpatient facility for dental procedures/services may be covered using the following criteria.

i. Anesthesia/Facility Coverage

01. Coverage is for dependent children less than 18 years of age only.

02. The Member must have a diagnosed medical or behavioral condition which requires outpatient hospitalization or general anesthesia when dental care is provided.

03. Services must be provided by a designated contracted facility and anesthesiologist.

04. Services rendered by a dentist are not a Covered Service; and

05. May require a Prior Authorization.

ii. For coverage limitations, please consult Your SOB and Prior Authorization list.

d. Orthodontia, dentures and bridges are not a Covered Service for any condition or diagnosis.

e. Orthognathic surgery is the surgical correction for congenital malposition of the bones of the jaw; the mandible, maxilla or both. The abnormality may be congenital, developmental or the result of disease. Orthognathic surgery may be considered Medically Necessary when non-surgical therapies fail and when Prominence HealthFirst's Technological Assessment Policy for orthognathic surgery is met. Prior Authorization may be required and coverage is limited.

i. The orthognathic surgical benefit is limited to one procedure per calendar year.

ii. For coverage limitations, consult Your SOB and Prior Authorization list.

f. Appliance therapy which does not permanently alter tooth position, jaw position or bite relationship.

The benefit for appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair and replacement of the appliance. Dental orthotics or appliances including, but are not limited to, oral appliances and night guards, are limited to one per calendar year.

g. Temporomandibular Joint Disorder (TMJ): Covered Services for any jaw joint problem, including TMJ disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the

joint linking the jaw bone and skull, include only medical services. Services or supplies, recognized dental procedures or, supplies, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints, are not covered.

h. Medical or surgical services related to TMJ or surgery are covered if this meets medical necessity.

Services must be provided by a n In-Network Practitioner/Provider.

i. The following are not Covered Services for TMJ:

01. CT Scans or magnetic resonance imaging (MRI) except in conjunction with surgical management;
02. Electronic diagnostic modalities;
03. Occlusal analysis
04. Any procedure not specifically listed as a Covered Service; and
05. Must comply with Prominence HealthFirst's technical assessment policy.

8. 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.

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

9. Diabetic Supplies and Services

a. Coverage is provided for insulin and insulin syringes, diabetic blood or urine test strips and lancets. Each item requires a separate prescription and is limited to one month supply per prescription. A Copayment applies per 100 strips. This benefit only applies if You do not have a pharmacy Rider or other pharmacy coverage and must be coordinated by an In-Network Practitioner/Provider and obtained from an In-Network pharmacy.

Services also include training and education.

b. Routine foot care.

c. Diabetic custom-made shoes and/or foot orthotics for diabetes are covered at two pair per Member per Calendar Year and must be prescribed by a Practitioner.

d. Routine retinal examination which does not include the determination of Refraction; and

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

10. Durable Medical Equipment

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

a. Coverage is provided for DME as prescribed and must be coordinated by an In-Network Practitioner/

Provider and may require Prior Authorization by Prominence HealthFirst.

b. DME must meet the Medicare and/or industry accepted standards and must be provided as a result of Medical Necessity and not be solely for convenience.

c. Repair, replacement and maintenance of authorized DME will be covered. Coverage is limited to normal wear, tear and growth change. There is no coverage for equipment which has been abused, stolen or improperly cared for; or for equipment solely for the purpose of travel.

d. Lymphedema Treatment: No more than two pair of pneumatic compression garments are covered per calendar year.

   i. Compression stockings: No more than four pair of individually fitted prescription graded compression stockings with more than 18 mm Hg are covered per calendar year.

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

11. Eating Disorders

a. Partial hospitalization, including residential treatment, for the treatment of Anorexia Nervosa, Bulimia Nervosa or Eating Disorders.

   i. Services must include medical supervision, including but not limited to, nutritional counseling and psychosocial counseling;

   ii. Facility must be appropriately accredited and/or licensed.

b. Medical Nutrition Therapy Counseling

   i. Coverage is provided for Medically Necessary Medical Nutrition Therapy/Nutritional Counseling, with PCP/Practitioner referral to a plan dietitian 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.

c. For coverage limitations, consult Your SOB and Prior Authorization list.

12. Emergency Care Services

Under the Affordable Care Act (ACA), Prominence HealthFirst is not permitted to charge higher copayments or co-insurance for Out-of-Network emergency room services, or require approval before seeking emergency room services from a provider or hospital outside the provider network.

The Prominence HealthFirst Emergency Services are provided as follows:

a. Without a Prior Authorization requirement, even for out-of-network services;

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

c. 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

d. 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.

e. If a member receives services from an out of network provider, they may be responsible for paying the difference between the billed charges and the plan's allowable rate. The plan's allowable rate is what the plan would have paid to an in-network provider.

f. As used in this section, "Medically Necessary Emergency Services" are healthcare services that are provided to a Member by a Practitioner/Provider after the sudden onset of a medical condition that is manifested by symptoms of sufficient severity that a prudent person would believe the absence of immediate medical attention could result in:

   i. Serious jeopardy to the health of a Member;

   ii. Serious jeopardy to the health of an unborn child;

   iii. Serious impairment of a bodily function; or

iv. Serious dysfunction of any body 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 Practitioner.

When You are seen in a contracted emergency room for a condition that was not Medically Necessary and that Prominence HealthFirst 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 HealthFirst will not pay benefits for services or supplies received outside of the Service Area if, in the opinion of the Plan Medical Director, the need for such services or supplies could have been foreseen before leaving the Service Area.

g. Emergency Services

i. Coverage for Emergency Services is available 24 hours a day, seven days a week.

ii. All follow-up care must be coordinated by an In-Network Practitioner/Provider.

iii. Follow-up care obtained through an emergency room or urgent care center is not a covered benefit.

h. Out-of-Area Emergency Services

i. Outside of the Prominence HealthFirst Service Area, coverage is provided for Medically Necessary covered Emergency Services at an Out-of-Network Practitioner/Provider, including medical and surgical care.

ii. In case of an emergency resulting in a Hospital admission, it is the Member's responsibility to ensure that Prominence HealthFirst is notified within 48 hours the next business day after the admission or as soon as reasonably possible.

iii. In case of Out-of-Country Emergency Services? Member must pay and submit receipts for reimbursement.

iv. If a member receives services from an out of network provider, they may be responsible for paying the difference between the billed charges and the plan's allowable rate. The plan's allowable rate is what the plan would have paid to an In-Network provider.

13. Genetic and Breast Cancer (BRCA) Counseling/Testing

The following services may require a Prior Authorization from Prominence HealthFirst:

a. Coverage is provided for Genetic Counseling/Testing as prescribed and must be coordinated by an In-Network Practitioner/Provider.

b. Genetic counseling and testing may only be done after consultation with an appropriately certified genetic counselor.

c. Genetic counseling and 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, abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, sickle cell anemia test or other genetic abnormality tests, 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 counseling and testing unrelated to pregnancy is covered in conjunction with covered genetic tests and in accordance with the guidelines of the American College of Medical Genetics (ACMG).

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

14. Health and Wellness Services

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

b. Health and Wellness Telephonic Coaching for Diabetes, Weight Management and Tobacco Cessation. Limited to a maximum of 6 sessions per Member, per year, per condition.

15. Hemophilia Services

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

16. Home Health Services

a. Medically Necessary care in the home requiring skilled services by healthcare professionals include, but are not limited to, nurses, physical therapists, respiratory therapists, speech therapists, occupational therapists and others, are a Covered Service for home bound patients. These medical services are Covered Services when coordinated by an In-Network Practitioner/Provider and obtained from an In-Network Practitioner/Provider. Short Term rehabilitation benefit limitations apply to Home Health services.

b. For coverage limitations, consult Your SOB and Prior Authorization list.

17. Hospice Care

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

a. Coverage is provided for drugs and medical supplies provided by the Hospital or Hospice.

b. Bereavement Services counseling limited to a maximum benefit of five (5) therapy sessions per year. Treatment must be completed within six (6) months of the date of death of the terminally ill Member.

c. Respite Services for a Hospice patient's family, including care for the patient which provides a respite from the stresses and responsibilities that result from the daily care of the patient and bereavement services provided to the family after the death of the patient. Inpatient Respite Services limited to a maximum benefit of five (5) days per calendar year.

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

18. Hospital Services

a. Inpatient Services: Coverage is provided for the following Medically Necessary Covered Services and must be coordinated by an In-Network Practitioner/Provider.

i. Semi-private room and board.

ii. Inpatient In-Network Practitioner/Provider Services.

iii. Private rooms are covered only when Medically Necessary.

iv. Laboratory, x-ray and other diagnostic services.

v. Drugs, medications, biologics and their administration.

vi. Use of operating and delivery rooms and related facilities.

vii. Anesthesia and oxygen services.

viii. 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.

ix. Radiation therapy, infusion therapy, and dialysis.

x. Blood and blood plasma products and their administration.

xi. Cardiac Rehabilitation Program Phase I.

b. Outpatient, Ambulatory and Surgical Services: Coverage is provided for the following Medically Necessary Covered Services.

i. Radiation therapy, infusion therapy and dialysis.

ii. Outpatient surgery and diagnostic services.

iii. Cardiac Rehabilitation Program Phase II.

iv. When Your outpatient status changes to inpatient, You will be responsible for an inpatient Copayment and or Deductible/Coinsurance.

v. For coverage limitations, consult Your SOB and Prior Authorization list.

c. Inpatient Skilled Nursing/Acute Rehabilitation Facility: Coverage is provided for Skilled Nursing/Acute Rehabilitation Facility services when Medically Necessary.

i. Coverage is provided for care in a Skilled Nursing/Acute Rehabilitation Facility, provided these services are of a temporary nature and lead to rehabilitation and increased ability to function.

ii. If You remain in a Skilled Nursing/Acute Rehabilitation Facility after discharge by an In-Network Practitioner/Provider, or after the maximum benefit period is reached, You will be financially responsible for all associated costs for the services.

iii. For coverage limitations, consult Your SOB and Prior Authorization list.

19. Infertility Testing and Services

Infertility Testing: Diagnostic testing for infertility is covered when coordinated by an In-Network Plan Practitioner/Provider. All services not listed below are excluded.

a. Diagnostic testing is limited to one testing series per Member per calendar year including, but not limited to, one of each of the following: general history and physical examination, progesterone level, VDRL, CBC, urinalysis, SMAC-12, T3, T4, TSH and T7, endometrial biopsy, HSG, Sims-Huhner, three separate semen analysis, semen culture, FSH, LH, follicular ultrasound and hysterosonography.

i. Limited diagnostic and therapeutic infertility services determined to be Medically Necessary and may require Prior Authorization by Prominence HealthFirst are covered services. Covered services do not include those services specifically excluded herein, but do include limited:

ii. Laboratory studies;

iii. Diagnostic procedures; and

iv. Artificial insemination services, up to six (6) cycles per Member per lifetime.

20. Kidney Dialysis Services

a. Coverage is provided for Medically Necessary kidney dialysis services and related therapeutic services and supplies, e.g., Epogen, to the extent not covered by the Medicare Program. These services must be coordinated by an In-Network Practitioner/Provider.

b. For coverage limitations, consult Your SOB and Prior Authorization list.

21. Laboratory and Pathology Services

a. Coverage is provided for Medically Necessary prescribed services when required to diagnose or monitor a symptom, disease or condition. Services include, but are not limited to, in network laboratory and pathology services when prescribed and coordinated by an In-Network Practitioner/Provider.

b. For coverage limitations, consult Your SOB and Prior Authorization list.

22. Maternity and Newborn Care

a. Maternity Care: Coverage is provided for Medically Necessary maternity care services for any hospital length of stay in connection with childbirth for a mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section.

However, You may be required to obtain Prior Authorization by Prominence HealthFirst for any days of confinement that exceed 48 hours (or 96 hours.) 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 or in the first 16 weeks for genetic testing or the need for fetal therapy.

iii. Use of Plan Hospital delivery room and related facilities.

iv. Use of Plan Newborn nursery and related facilities.

v. For coverage limitations, consult Your SOB and Prior Authorization list.

23. Mental Health And Substance Abuse Benefit

Prominence HealthFirst will provide mental health and substance abuse benefits to covered Members subject to all conditions, limitations, and exclusions listed in the Evidence of Coverage document. Refer to the SOB document for the corresponding copayment amount for each covered service.

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 Plan Practitioner/Provider and Prior Authorized.

ii. **Inpatient/Residential Rehabilitation:** Coverage is provided when there has been a history of multiple outpatient treatment failures or when outpatient treatment is not feasible.

iii. **Detoxification:** Coverage is provided for treatment for withdrawal from the physiological effects of alcohol and drug abuse. Inpatient detoxification is considered appropriate treatment only for life-threatening withdrawal syndromes associated with drug and alcohol dependence.

iv. **Outpatient Rehabilitation/Day Treatment:** Coverage is provided for Medically Necessary Covered Services for the abuse of alcohol or drugs when coordinated by an In-Network Practitioner/Provider and may require Prior Authorization. Depending on the duration of the Outpatient Rehabilitation program, this benefit may require Members to pay the Hospital Outpatient share of cost which is found on the Member's SOB.

v. **Counseling Services / Outpatient Office Visits:** Coverage for individual or group counseling is provided for covered Members for Medically Necessary covered outpatient counseling services related to the abuse of alcohol or drugs.

b. Mental Health Disorders Benefit Description

i. **General Mental Health Services:** Coverage is provided for outpatient mental health services, when coordinated and may require Prior Authorization by an In-Network Practitioners/Providers. Services are limited to evaluation, crisis intervention and short-term psychotherapy which will lead to significant clinical improvement and achieve treatment goals. Examples of Covered Services include phobias, bereavement, marriage and family therapy. Services include outpatient office visits with a mental health professional.

ii. **Severe Mental Illness:** Coverage is provided for Medically Necessary severe mental illness services when coordinated and may require Prior Authorization by an In-Network Practitioners/Providers. Treatment is limited to the following conditions: schizophrenia, schizo affective disorder, bipolar disorder, major depressive disorders, panic disorders and/or obsessive compulsive disorder.

01. Severe Mental Illness benefits include Inpatient treatment, Outpatient Office Visits and Day Treatment Programs.

02. Depending on the duration of the Day Treatment Program, this benefit may require Member to pay the Hospital Outpatient share of cost which is found on the Member's SOB.

c. For coverage limitations, consult Your SOB.

24. Morbid Obesity

a. Bariatric Restrictive Services are covered when all of the following have been determined and are limited to one procedure every three years:

i. The Member must have either:

01. BMI ≥ 40 kg/m2 without co-morbidities;

02. BMI ≥ 35 kg/m2 and a high-risk obesity-related condition or a combination of three other obesity-related diseases or cardiovascular risk factors (documented evidence of risk factors required)

001. High risk diseases are Chronic coronary disease, atherosclerosis, Type 2 diabetes or sleep apnea.

002. Other obesity-associated diseases include osteoarthritis, gallstones, stress incontinence and gynecologic abnormalities.

003. Must be at least 18 years of age.

004. 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, family history of premature CHD.

b. 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 low-calorie dieting, increased physical activity, behavioral therapy and pharmacotherapy, where appropriate.

i. The less invasive therapy must have been in place for more than a continuous six month period.

ii. Failure of less invasive methods is determined by the Plan Medical Director and his/her designee.

c. Member has been obese for at least five years;

d. If Member is diabetic, disease is controlled;

e. Member must have the capacity to be compliant with post-surgical treatment or follow-up requirements, which may include a psychiatric or behavioral evaluation;

f. Procedure must be performed at an In-Network facility unless pre-approved by Prominence HealthFirst to be performed at an Out-of-Network Facility/Provider; and

g. Tobacco free for (8) eight weeks prior to surgery.

h. For coverage limitations, consult Your SOB and Prior Authorization list.

25. Nutritional Supplements, Enteral Therapy and Parenteral Nutrition

a. Coverage is provided for enteral formulas for use at home when prescribed or ordered by an In-Network Practitioner/Provider as medically necessary or the treatment of "inherited metabolic diseases" characterized by deficient metabolism or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and

b. Special food products which are prescribed or ordered by an In-Network Practitioner/Provider as medically Necessary for treatment mandated by Nevada State Law (NRS 695C.1723).

c. As used in this section:

i. "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

ii. "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

d. If a Member does not have an inherited metabolic disease, but whose sole source of alimentation (nutritional intake) is by enteral formula, then they too are entitled to coverage.

e. Total Parenteral Nutrition (TPN) received in the home is a covered benefit for 21 days when it is determined to be Medically Necessary. Continuation of TPN may be considered if Medically Necessary upon review every 21 days.

f. For coverage limitations, consult Your SOB and Prior Authorization list.

26. Organ Transplant Services

Coverage is provided for Medically Necessary Covered Services for the non-experimental organ transplants listed below, for the treatment of non-occupational disease or injury. All transplant-related services may require Prior Authorization from the Prominence HealthFirst's 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. There is no coverage for a Member acting as a transplant donor to a non Prominence HealthFirst Member.

d. Transplants utilizing any animal organs are not a Covered Service.

e. Procedures must be performed at a Prominence HealthFirst transplant network facility.

f. For coverage limitations, please consult Your SOB and Prior Authorization list.

Combined expenses incurred for any and all human body organ transplant services, including followup care, Home Healthcare, immunosuppressive medications and donor expenses for non-experimental human-to-human procedures. Immunosuppressive post transplant medications may be covered under the medical plan or pharmacy benefit depending on the prescription drug dispensed. Immunosuppressive post transplant self injectables are covered with a 20% Member responsibility (coinsurance).

27. Plastic and Reconstructive Surgery

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

a. Reconstructive surgery is incidental to or follows surgery resulting from Acute trauma, infection or other diseases of the involved body part.

b. Surgery for a Congenital disease or anomaly has caused a functional defect, but only when the surgery is reasonably expected to correct the condition.

c. Reconstructive surgery following a mastectomy when medically necessary on one or both breasts to reestablish symmetry. This benefit includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

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

28. Prescription Drug Benefit

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

i. **Plan Pharmacy:** a pharmacy contracted with Prominence HealthFirst to dispense Prescription Drugs to Members for benefits under the prescription drug benefit. The Plan Pharmacy list is available from Prominence HealthFirst.

ii. **Out-of-Network Pharmacy:** a pharmacy not contracted with Prominence HealthFirst as a Plan Pharmacy.

a. **Prescription Drug (or "Prescription"):** drugs or medications which, according to federal law, can only be obtained legally with a written prescription from a licensed practitioner; it's required to bear a label which says, "Caution: Federal Law Prohibits Dispensing without a Prescription," or is restricted to prescription dispensing by state law. The drug must have received final approval from the (FDA) for the indicated use.

b. **Preferred Drug List:** Prescription drug coverage requires Members to use the Prominence HealthFirst Preferred Drug List (PDL). This list of medications is created and maintained by the Prominence HealthFirst Pharmacy and Therapeutics Committee, based upon current medical standards of practice. Some medications on the Preferred Drug List may require Prior Authorization and/or have a limited benefit. Approved U.S. Food and Drug Administration (FDA) female oral contraceptive generic drugs are listed in the PDL. If You wish to receive a copy of the Prominence HealthFirst Preferred Drug List, please contact the Member Services Department at 775.770.9310 or 800.863.7515.

i. **Pharmacy and Therapeutics Committee:** the Pharmacy and Therapeutics Committee, at least on an annual basis, reviews new and existing categories of drugs, using the recommendations of medical and surgical specialists, pharmacists and other healthcare professionals in their decision making process. The evaluation of drugs for inclusion on the Preferred Drug List is based on information from reference medical and pharmacy journals, and standards of practice. Preferred drug evaluations are based on several factors:

- FDA-approved indications
- Efficacy
- Adverse effect profile
- Patient monitoring requirements
- Impact on total healthcare costs
- Comparison to other preferred agents

c. **Covered Contraceptive Pharmaceuticals:** Oral contraceptive drugs and other FDA approved medications and devices prescribed for birth control. FDA approved female Oral Contraceptive Generic Drugs and select preventive medications listed on the preferred drug list require no Member share of cost when prescribed by Your Primary Care Practitioner or other Prominence HealthFirst In-Network Practitioner/Provider and obtained from a Prominence HealthFirst Plan Pharmacy.

d. Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand Drugs, require payment of the prescribed copayment as listed in the Prominence HealthFirst SOB document. Member must pay the copayment to the Plan Pharmacy at the time the Prescription is filled, for each prescription or refill dispensed, up to a 30-day supply, unless limited by the Prominence HealthFirst Preferred Drug List. Covered Generic, Preferred Name Brand and Non-Preferred Name Brand Drugs are listed on Prominence HealthFirst's Preferred Drug List (PDL).

i. **Generic Drug:** a prescription drug chemically equivalent to a Name Brand Drug whose patent has expired. The drug's generic/brand status may change without notice.

ii. **Preferred Name Brand Drug:** a prescription drug patented and given a brand or trade name by the drug manufacturer.

iii. **Non-Preferred Name Brand Drug:** A Name Brand Drug which often has a Generic equivalent, and which is listed on the PDL.

e **Specialty Pharmacy:** Some Specialty Drugs require the member to obtain the drug through the Prominence HealthFirst Specialty Drug provider. Contact Member Services for more information.

f. **Maintenance Drugs:** Drugs listed in Prominence HealthFirst's maintenance drug list of the Preferred Drug List (PDL) and are 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.

g. **Diabetic Supplies:** Mail order diabetic blood test strips, urine test strips, syringes and lancets require two copayments for each 300 quantity of Preferred Brand supply or three copayments for each 300 quantity of Non-Preferred diabetic supply. For additional information about Diabetic Supplies, see the Diabetic supplies and services section of this document.

h. **Dispense as Written Provision:** Prescription Drugs will always be dispensed as ordered by Your physician. You may request, or Your physician may order, the Name Brand Drug. However, if a Generic Drug is available, You will be responsible for the cost difference between the Generic and Name Brand Drug, in addition to Your Generic copayment.

i. **Step Therapy:** the process for determining the best medication to help treat an ongoing condition such as arthritis, asthma, or high blood pressure. One drug must be dispensed and tried before dispensing the next drug for the condition – this is known as "steps" of therapy. Step Therapy requires use of one of more medications before a similar, more expensive, Name Brand Drug is dispensed. This means that Step Two drugs will not be covered until Step One prescription drugs are tried first, unless Your physician contacts Prominence HealthFirst to obtain a Prior Authorization list. Drugs which require Step Therapy are listed in Prominence HealthFirst's Preferred Drug List (PDL)

j. Prescription Drug Benefit Exclusions

i. **Cosmetic and Aging of the Skin Products:** cosmetic products, health and beauty aids including all products used to retard or reverse the effects of aging of the skin, whether prescription or nonprescription, and any drugs/products for the treatment of hair loss.

ii. **Dietary Aids and Appetite Suppressants:** dietary or nutritional products, including prescription or non-prescription vitamins (except those prescribed pre-natal vitamins listed on the Prominence HealthFirst Preferred Drug List), appetite suppressants, and diet pills used for weight reduction, except as otherwise permitted in the EOC and SOB documents.

iii. **Experimental or Investigational:** drugs labeled "Caution: Limited by Federal Law to Investigational Use," as well as drugs either not approved by the Federal Drug Administration as "safe and effective" or, if so approved, which are intended to treat a condition for which the U.S. Food and Drug Administration (FDA) has not approved its use, whether used on an inpatient or outpatient basis, except as otherwise permitted under Federal or State law.

iv. **Fertility Drugs:** Drugs/Products used for the treatment of impotence or infertility, except as otherwise permitted in the EOC and SOB documents.

v. **Smoking Cessation:** smoking cessation drugs and/or aids whether Prescription or Non-Prescription (unless used in conjunction with the Prominence HealthFirst smoking cessation program).

vi. Nail Fungal Medications and/or Preparations.

vii. **Non-Covered Drugs:** any prescription drug prescribed in connection with a Non-Covered Service. This includes any drug not listed on the Preferred Drug List.

viii. **Non-Approved Drugs:** drugs determined by the Prominence HealthFirst Pharmacy and Therapeutics Committee as ineffective, duplicative, or having preferred formulary alternatives.

ix. **Over-the-Counter Drugs:** over-the-counter drugs and other items which do not require a written prescription (even if ordered by a Prominence HealthFirst In-Network Practitioner/Provider).

29. Preventive Services

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

c. Baseline and periodic mammography for females as recommended by Your Primary Care Physician or as per recommendations from the U.S Preventive Services Task Force.

d. Prostate screening as recommended by Your Primary Care Physician or as per recommendations from the U.S Preventive Services Task Force.

e. Well child visits and annual physicals as recommended by Your Primary Care Physician 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 Physician or as per recommendations from the U.S Preventive Services Task Force Screening does not include determination of refractive state. Frames and lenses for the care of Strabismus (cross-eyed) are limited to one exam per calendar year.

g. Childhood and adolescent immunizations, vaccinations and state mandated immunizations as per recommended by the Advisory Committee on Immunization Practices are covered.

h. Adult immunizations and vaccinations as per recommendations from the Advisory Committee on Immunization Practices are covered.

i. Colorectal cancer screening in accordance with the guidelines published by recommendations from the U.S Preventive Services Task Force unless age limits are removed by Prominence HealthFirst.

j. Vaccines for human papillomavirus at such ages as per recommendations from the Advisory Committee on Immunization Practices.

k. Women's Preventive Services

i. (FDA) approved contraceptive products.

ii. Domestic and interpersonal violence screening and counseling.

iii. Well-woman visits.

iv. BRCA genetic counseling and testing services.

v. Gestational diabetes screening.

vi. Human Papillomavirus (HPV) DNA testing, for women 30 or older.

vii. Sexually transmitted infections (STI) counseling.

viii. HIV Screening and Counseling

ix. Breastfeeding support, supplies, and counseling.

x. For coverage limitations, consult Your SOB and Prior uthorization list.

xi. For more information visit the US Preventive Services Task force at http://www.uspreventiveservicestaskforce.org/Tools/ConsumerInfo/Index/information-for-consumers

30. Professional Services

a. **In-Network Practitioner/Provider Office Visits:** Medically Necessary Covered Services are provided for the diagnosis and treatment of illness or injury when provided in the medical office of a Plan Practitioner/Provider. To access specialty care, you may be required to obtain an authorization from Your PCP prior to receiving specialty care. Call Member Services for a complete listing prior to receiving specialty care. Failure to obtain appropriate Referrals and/or Authorizations may result in You being financially responsible for all associated charges.

b. **In-Network Practitioner/Provider Hospital Visits:** Medically Necessary Covered Services for diagnosis, treatment and consultation are provided for inpatient and outpatient Prior Authorized Hospital Services.

c. **In-Network Practitioner/Provider Home Visits:** Medically Necessary care in the home requiring skilled services by healthcare professionals including, but not limited to nurses, physical therapists, respiratory therapists, speech therapists and occupational therapists are a Covered Service for homebound patients.

31. Prosthetic and Orthotic Devices

a. Prosthetic devices which aid body functioning or which replace a limb or body part after accidental or

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

b. Orthotics and artificial aids, such as cardiac pacemakers and artificial heart valves, are a Covered Service when Medically Necessary.

c. Foot orthotics are limited to one pair per Member per Calendar Year.

d. The Prosthetic or Orthotic devices are defined by the Medicare DME guidelines.

e. Benefits are provided for the initial prescription lenses, eyeglasses or contact lenses, following an operation for cataracts and post-corneal transplants. Eyeglasses and contact lenses are limited to one basic pair per calendar year.

f. Prescription lenses, eye glasses or contact lenses for treatment of keratoconus are limited to one basic pair per calendar year.

g. For coverage limitations, please consult Your SOB and Prior Authorization list.

32. Radiology and Diagnostic Services

a. Coverage is provided for Medically Necessary prescribed 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 complex diagnostic scanning when coordinated by an In-Network Practitioner/Provider.

b. Coverage is provided for Diagnostic Colonoscopy and Sigmoidoscopy as Medically Necessary.

c. For coverage limitations, please consult Your SOB and Prior Authorization list.

33. 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).

c. If no improvement is documented within the initial two weeks, additional spinal manipulation treatment is not Medically Necessary and is not covered unless the spinal manipulation treatment is modified.

d. If no improvement is documented within 30 days despite modification of spinal manipulation treatment, continued spinal manipulation treatment is not considered Medically Necessary and is not covered. Once the maximum therapeutic benefit has been achieved, continuing spinal manipulation is not considered Medically Necessary and thus is not covered.

e. Coverage for pediatric patients, ages 0-11, is only authorized for spinal manipulation, and only when Medically Necessary.

f. For coverage limitations, please consult Your SOB and Prior Authorization list.

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 Practitioner/Provider. Outpatient Short Term Rehabilitation Services are limited to treatment of conditions the Prominence HealthFirst's Plan Medical Director determines to result in significant clinical improvement. These therapies are limited to 60 visits per condition, per Member per calendar year.

b. **Habilitative Services:** Healthcare 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. These therapies are limited to 60 visits per condition, per Member per calendar year.

c. **Rehabilitative Services:** Limited to 60 visits per Member per calendar year.

d. **Autism Spectrum Disorder** - is a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.

i. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

- Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
- Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.
- The maximum number of therapy treatments per Member is limited to 200 services per year.
- For coverage limitations, please consult Your SOB and Prior Authorization list.

35. Telehealth Services

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

36. Urgent Care Services

a. Urgent/Ambulatory Care Services

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 which should be treated within 24 hours. Routine or follow-up care is not considered urgent care and must be provided by Your PCP. When You are seen in an In-Network/Ambulatory Care facility for a condition not Medically Necessary and that Prominence HealthFirst determines did not require Urgent/Ambulatory services, or fail to follow the proper procedures as defined above, You will be held financially responsible for all charges related to this visit. In addition, Prominence HealthFirst will not pay benefits for services or supplies received outside of the Service Area if, in the opinion of the Medical Plan Director, the need for such services or supplies could have been foreseen before leaving the Service Area. In addition, Prominence HealthFirst will not pay benefits for services or supplies received at an Out-of Network Practitioner/ Provider within the Service Area.

b. In-Area Urgent/Ambulatory Care Services

All Medically Necessary Urgent/Ambulatory Care services must be obtained through a contracted Urgent/Ambulatory Care In-Network Practitioner/Provider. Continuing or follow-up care for an Urgent/ Ambulatory Care service must be provided by Your PCP. Any continued or follow-up care a Member receives at an Urgent/Ambulatory Care facility is not a Covered Service.

c. Out-of-Area Urgent/Ambulatory Care Services

Out-of-Area Urgent/Ambulatory Care services are covered for Medically Necessary Covered Services.

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

37. Vision Care Services-for children 19 and under.

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 Member per Calendar year for individuals age 19 and under.

b. Coverage is provided for prescribed corrective lenses and eyeglass frames as follows:

i. Frames and/or Prescribed Corrective Lenses:

ii. Prescribed Corrective Contact Lenses:

iii. This benefit is limited to one pair of basic glasses (Frames and Prescribed Corrective Lenses) per Member per Calendar Year. Prescribed corrective contact lenses are limited to one pair per Member per Calendar Year. Six (6) pairs of Contact Lenses can be substituted in lieu of glasses.

iv. Vision Care Services are covered to the maximum allowance or billed charges, whichever is less:

01. Upon proof of payment by Member; or

02. Upon receipt of a claim/billing form from provider

38. 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 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.

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 VIII. Exclusions, Limitations and Non-Covered Services

Any service or item not considered Medically Necessary by an In-Network Practitioner/Provider. The final determination of Medical Necessity is the judgment of the Prominence HealthFirst 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, including treatment of complications resulting from surgical treatment of and/or morbid obesity, except as otherwise permitted in this EOC.
2. **Chelation Treatment** - Chelation Therapy, except for recognized or standard medical care to treat heavy metal poisoning.
3. **Complication of non-covered service** - Complications resulting from excluded a) cosmetic treatment or b) 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. Supplies and consumables including, but not limited to, dressing, any equipment to condition the air, appliances, ambulatory apparatus, heating pads, personal care or beautification items, deluxe equipment, wheel chair lifts, fourchannel muscle stimulators and any other primarily non-medical equipment. Special equipment and devices used for sports.
5. **Compression stockings** - Compression stockings with a pressure gradient of less than 18mm Hg including but not limited to, elastic stockings, surgical leggings, anti-embolism stockings (Ted Hose) or pressure leotards.
6. **Cosmetic services** - Cosmetic surgery or treatment defined as any plastic or reconstructive surgery or procedure done primarily to improve the appearance of any portion of the body in the absence of specific functional limitations from which no substantial clinical improvement in physiologic function could be reasonably expected. Cosmetic Exclusions include, but are not limited to, the following:
   a. Abdominoplasty, regardless of medical necessity;
   b. Surgery for sagging or extra skin; to include thigh, leg, hip, buttock, arm, forearm and hand, regardless of medical necessity;
   c. Face lifts, brow lifts and rhinoplasty, regardless of medical necessity;
   d. Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedure to alter Refraction;
   e. Any augmentation or reduction procedures or correction of facial or breast asymmetry. Breast augmentation, lifts or reductions which are not associated with cancer of the breast, regardless of medical necessity; or any removal of breast implants or breast reconstruction which is not associated with breast cancer.
   f. Hair removal or treatment of baldness;
   g. Scar revision therapy and laser services for scars;
   h. Any implant, appliances or devices used to improve the appearance and/or function of portion of the body, regardless of medical necessity;
   i. Earring injuries and/or earlobe repairs;
   j. All body peircings;
   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, except as otherwise permitted in this EOC.

l. Psychological factors, e.g., for self-image, difficult social or peer relations, are not relevant and do not constitute a physical bodily function. Examples of Non-Covered Services include, but are not limited to, tattoo removal, liposuction and wigs.

7. **Court ordered services** - Court ordered treatments including, but not limited to, long-term mental health, chemical dependency and psychiatric treatment. Pretrial or court testimony and/or the preparation of court-related reports are also not covered under this EOC, as well as, any care or service while incarcerated.
8. **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, except when related to accidental injury to sound natural teeth.
   a. Treatment or replacement of any tooth or any supporting tooth structure, alveolar process or disease of the periodontal or gingival tissue;
   b. Surgery or splinting to adjust dental occlusion;
   c. Treatment of jaw disorders;
   d. Maxillary or mandibular surgery, except as otherwise permitted in this EOC;
   e. Any irreversible procedure including, but not limited to, orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures.
9. **Dermatology** – Removal of a benign skin lesions is considered cosmetic except as defined in section VII, #8.
10. **Developmental and educational testing or treatment** - Testing and treatment for educational or behavioral disorders, non-medical ancillary services such as work hardening treatment, vocational rehabilitation, cognitive therapy, employment counseling return-to-work evaluations. Services, treatment and evaluation for Developmental Delays, speech therapy which is educational in nature and any other education services which are provided through a school district, special school, learning center, treatment and services for learning disabilities and Developmental Delays.
11. **Double coverage** - 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.
12. **Duplicate Items** - Duplicate items, services, supplies or equipment to be used outside the home or for work or travel.
13. **Examinations/Immunizations** - Physical examinations or immunizations when required for employment, insurance, licensing, marriage, sports, education or travel and physical or work hardening capacity examinations.
14. **Experimental/Investigation** - Any services that determines to be experimental or investigational medical, surgical or other procedures or treatments, including prescription medications unless otherwise directed by State or Federal regulations. 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 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 HealthFirst'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;

f. When the treatment or service require approval by any governmental authority prior to use and such approval has not been granted when the treatment or services is to be rendered.

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

16. **Infertility treatment/services** - Embryonic transfer, Gamete intra-fallopian transfer (GIFT), in vitro fertilization and sperm donation (including storage of) or any related services for treatment of infertility.

    Additional Exclusions include, but are not limited to, the following:

    a. Advanced reproductive techniques such as embryo transplants, in vitro fertilization, GIFT and ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;

    b. Home pregnancy or ovulation tests;

    c. Sonohysterography;

    d. Monitoring of ovarian response to stimulants;

    e. CT or MRI of sella turcica unless elevated prolactin level;

    f. Evaluation for sterilization reversal;

    g. Laparoscopy;

    h. Ovarian wedge resection;

    i. Removal of fibroids, uterine septae and polyps;

    j. Open or laparoscopic resection, fulguration, or removal of endometrial implants;

    k. Surgical lysis of adhesions;

    l. Surgical tube reconstruction.

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

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

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

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

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

21. **Limitations** - In the event that due to circumstances not within the control of the Health Plan including, but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the In-Network Practitioner/Provider's personnel or similar causes, the rendering of Professional or Hospital Services provided under this EOC is delayed or rendered impractical, the Health Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Health Plan and In-Network Practitioner/Provider shall render Hospital and Professional Services provided under this EOC in so far as practical, and according to their best judgment; but the Health Plan and In-Network Practitioner/Provider shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.
22. **Long-term treatment** - Long-term mental health, chemical dependency and psychiatric treatment. Services or treatment for mental retardation or chronic mental illness, the monitoring of medications prescribed for such conditions, enrollment in special schools and Residential Treatment, unless mandated by Nevada or Federal Law.
23. **Maternity** - Childbirth outside of the Service Area if the Member has entered her third trimester of pregnancy, unless travel was supported by a Practitioner recommendation. Unless otherwise excluded please refer to the section entitled "Maternity and Newborn Care." Amniocentesis, except as otherwise permitted in this EOC. Collection and banking of cord blood is not covered. Doulas are specifically excluded.
24. **Medical services** - Services or benefits not provided by a Prominence HealthFirst In-Network Practitioner/Provider or not obtained in accordance with Prominence HealthFirst's Prior Authorization requirements, except for Emergency care or as covered under the Coordination of Benefits provisions. Services that are not Medically Necessary or not required in accordance with accepted standards of medical practice. Services obtained outside of the Service Area for an absence exceeding 90 days, except as otherwise permitted in this EOC. Payment for services which would normally be provided without charge, or services for which the Member would not otherwise be considered financially liable. Benefits or services rendered outside of the United States, except for Emergency Services.
25. **Never Events** - The National Quality Forum has identified certain events as occurrences that should never happen in a hospital and can be prevented. They termed them "serious reportable events" or never events. "Never events" are excluded from coverage. They include but are not limited to the following:
    a. Air embolism, blood incompatibility, object left during surgery, catheter-associated urinary tract infections, pressure (decubitus) ulcers, vascular catheter-associated infection, surgical site infection, mediastinitis after coronary artery bypass graft (CABG) surgery, surgery performed on the wrong body part, surgery performed on the wrong patient, wrong surgical procedure performed, criminal events (e.g., sexual assault of a patient), falls and trauma, burns, electric shock, legionnaires disease, failed glycemic control (e.g., Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Hypoglycemic Coma), iatrogenic pneumothorax, delirium, ventilator associated pneumonia, Staphylococcus aureus septicemia, clostridium difficile-associated disease (CDAD), and hospital acquired injuries.
26. **Non-covered providers of service** - Membership costs for health clubs, weight loss clinics, sports medicine treatment and similar programs. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, nursing home or any similar institution. Services provided by a person who lives with You in Your home or is a part of Your family. Private duty nursing and private Hospital rooms, Custodial Care, board and care, rest homes or homemaker services. "Custodial Care" is defined as care that serves to assist an individual in the activities of daily living. Institutional care which is determined by the Plan Medical Director to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures. Supplies, medical care or treatment given by one of the following

Members of the Member's immediate family:

a. The Member's spouse.

b. A child, brother, sister, parent or grandparent of either the Member or the Member's spouse.

c. Service or supplies rendered by someone who is related to an Insured Person by blood, e.g., sibling, parent, grandparent, child, marriage (e.g., spouse or in-law) or adoption or is normally a Member of the Insured Person's household.

d. Charges for treatment by an In-Network Practitioner/Provider that are not within the scope of his/her license.

27. **Non-covered therapies/services** - Biofeedback, hypnosis, aromatherapy, aquatic therapy, massage therapy, rolfing therapy, sleep or snoring treatment, (except for central or obstructive apnea), behavior modification training or therapy, milieu therapy, sensitivity training, electronarcosis, reflexology, health spas, kinesiology, prolotherapy, auditory integration therapy, metabolic activation, CIIIT (Chronic Intermittent Intravenous Insulin Therapy) or PIVIT (Pulsat IV Insulin Therapy).
28. **Pharmacy/drugs** - Costs related to the acquisition or use of medical marijuana. Prescribed drugs and medications including take-home drugs and medications incidental to a Hospital admission except when provided as part of an inpatient admission, or pursuant to a Prominence HealthFirst Supplemental Coverage Rider for Prescription Drugs in accordance with the Prominence HealthFirst Preferred Drug List. Over-the-counter drugs, homeopathic, herbal medications and other substances not requiring a prescription even if ordered by a prescription from an In-Network Practitioner/Provider, drugs administered in an In-Network Practitioner/Provider's office, if other than immunizations, allergy serum and chemotherapy drugs. Self-injectables (unless otherwise covered under pharmacy Rider), except for diabetic medications and supplies, except as otherwise permitted in this EOC.
29. **Residential Treatment** - Residential Treatment, not provided by an accredited facility and not prior authorized.
30. **Saliva Testing** - Costs related to saliva testing.
31. **Self-inflicted Injuries** - Injuries generally covered under the Plan are excluded if they were self-inflicted or were sustained in connection with a suicide or attempted suicide, unless the injuries resulted from a medical condition such as depression, or from an act of domestic violence or as defined by Federal law.
32. **Sexual dysfunction** - Penile implants and any related sexual devices, appliances, services or medications for sexual dysfunction.
33. **Special training/treatment** - Sensitivity training, educational training therapy or treatment for an education requirement. Ecological or environmental medical diagnosis and/or treatment.
34. **Spinal treatment** - Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, when such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Vertebral Axial Decompression (VAX-D), Back to Back, Orthotrac Pneumatic Vest, Back Friend, spinal manipulation for Chronic conditions, maintenance, and/or preventive therapy.
35. **Third opinions** - Opinions and consultations beyond the second opinion.

Third opinions are typically not covered unless medically necessary and requested by an In-Network Practitioner/Provider.

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

37. **Travel** - Travel, accommodations and oxygen provided while traveling on an airplane whether or not recommended or prescribed by a Practitioner/Provider.
38. **Urgent Care Services** - Urgent Care Services obtained inside the Service Area by an Out-of-Network Urgent Care facility.
39. **Vision** - Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedures to alter Refraction; or complications resulting from the procedure. Ophthalmological/ Vision services provided in connection with the testing of visual acuity or determination of refraction error for the fitting of eyeglasses or contact lenses. The furnishing or replacing of eyeglasses or contact lenses will not be a benefit, except when following cataract surgery including eye exercise therapy. These exclusions only pertain to adult vision services.

    The following items are specifically excluded under this benefit:

    a. Safety glasses required for employment

    b. Non-prescription glasses and contact lenses

    c. Tinted contact lenses not used for corrective purposes

    d. Glass lenses for Members through age 19

    e. Non-prescription sports related protective eye wear
40. **War-related services** - Services or supplies received as a result of war, declared or undeclared, or international armed conflict.
41. **Weight Loss/Gain Services** - Special diet or food supplement programs, products or medications for weight loss and weight-loss programs. Residential Treatment programs for obesity and/or morbid obesity and/or Residential Treatment for weight gain.
42. **Work-related injuries** - Work-related injuries and/or illnesses, including those not covered by a workers' compensation policy.

Part IX. Plan Administration

1. All Medical Prominence HealthFirst In-Network Practitioners/Providers are independent contractors. In-Network Practitioners/Providers are not agents of Prominence HealthFirst, nor is Prominence HealthFirst or any of its employees, an employee or agent of In-Network Practitioners/Providers. Prominence HealthFirst 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 Practitioner/Provider.
2. In-Network Practitioner/Providers maintain a professional Practitioner-patient relationship with You to coordinate Your healthcare services. If You are unable to establish an acceptable relationship, You may request to change Practitioners. Likewise, Your Practitioner may request that You change to another Practitioner.
3. You may, for personal reasons, refuse to accept procedures or treatment by an In-Network Practitioner/Provider. In-Network Practitioners/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 In-Network Practitioner/Provider believes to be appropriate medical care. If You continue to refuse the recommended treatment, neither Prominence HealthFirst nor the In-Network Practitioner/Provider will be responsible for treatment of the condition or any services required.
4. The Premium charges for this EOC shall be determined by Prominence HealthFirst, subject to the approval of the applicable State regulatory agencies.

   a. Premium payment is due on or before the first day of the month for which coverage is provided.

   b. Only when Your Premium payment has been received are You entitled to healthcare services under this EOC. A Grace Period of 30 days will be allowed.

   c. Prominence HealthFirst reserves the right to change the total monthly Premium for the health benefits plan and/or Riders prior to renewal after 60 days' written notice, provided such changes are in accordance with the provisions set forth in this EOC.
5. Prominence HealthFirst reserves the right to revise this EOC, SOB and any applicable Riders, in accordance with Federal or State regulatory agencies. Such revisions shall be made upon 60 days' advance written notice to the Individual.
6. For the initial claim, Providence HealthFirst reserves to itself and its designated administrators the right to interpret or construe the terms of this SOB, to resolve all questions concerning the status and rights of Subscribers and others under the SOB, including, but not limited to, eligibility for benefits, and to make any other determinations it deems reasonable in the administration of the SOB, the right to revise this SOB, 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 XVI, "Notice of Privacy Practices," Part XV, "Internal Claims and Appeal Procedures."
7. The Member ID Card issued by Prominence HealthFirst pursuant to this EOC is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this EOC, and misuse of such Identification Card constitutes grounds for termination of coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this 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 which 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.

8. Transfer of Medical Benefits from Prior Plan:

   a. Employee may not be actively at work; or

   b. Your Dependents may be confined in a Hospital or Skilled Nursing Facility.

   c. The level of benefits provided by this provision for any illness will be reduced by any benefits payable by the prior policy.

   Coverage under this provision will be continued until the earliest of:

   d. The date the lifetime maximum benefit of the prior policy is reached;

   e. The date You or Your Dependents are eligible under the other provisions of this EOC.

Part X. Termination of Coverage

1. TERMINATION OF COVERAGE 45 CFR § 155.430

During the course of the benefit plan year, either the enrollee, Healthcare.gov, or Prominence HealthFirst may need to terminate an enrollee's coverage in a plan. The following events may trigger a termination:

a. **Voluntary Termination** - An enrollee provides notice to Healthcare.gov, or Prominence HealthFirst that the enrollee would like to terminate coverage;

b. **Loss of Eligibility** - The enrollee is no longer eligible for coverage in a QHP through Healthcare.gov;

c. **Non-payment** - An individual fails to pay premiums by the appropriate deadlines and the following grace periods have been exhausted:

i. For an individual eligible to receive APTC, the 3-month grace period provided by Healthcare.gov has been exhausted; and

ii. For individuals not eligible to receive APTC, the 30 day grace period has been exhausted;

iii. **Rescission** - The enrollee's coverage is rescinded by the carrier;

iv. **Withdrawal of Product or Decertification** - The plan is withdrawn by the carrier and terminates or is decertified by Healthcare.gov; or

v. The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period.

For the purposes of this section, reasonable or appropriate notice is defined as fourteen days from the requested effective date of termination.

2. Voluntary termination by the enrollee, the last day of coverage is;

a. The termination date specified by the enrollee, if the enrollee provides reasonable notice.

b. Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice.

c. On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to complete the termination in fewer than fourteen days and the enrollee requests an earlier termination effective date.

d. If the enrollee is newly eligible for Medicaid, Medicare, or CHIP, the last day of coverage is the day before such coverage begins.

3. Termination for non-payment coverage ends:

a. For individuals who are eligible for the Advance Premium Tax Credit, on the last day of the month for which premium payment was received in full during the non-payment grace period, but no earlier than the last day of the first month of that grace period.

b. For individuals who are not eligible for the Advance Premium Tax Credit, on the last day of the month for which premium payment was received in full.

In the case of termination due to the enrollee changing from one QHP to another during an annual open enrollment period or special enrollment period, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.

Regardless of the date of termination, premium payments are never prorated. If coverage is in effect on the first of a month, full premium payment will be billed and is due for that month.

4. Individual coverage, including this EOC, may be terminated in the following ways:

a. For any Dependent Member who is no longer eligible for coverage as a Dependent.

b. If You willfully and knowingly permit another person to use Your ID card.

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

1. **Nonduplication:** Prominence HealthFirst will provide You with full healthcare services within the limits of this Evidence of Coverage. Prominence HealthFirst 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 HealthFirst will not pay for benefits for conditions in which coverage is available under the workers' compensation law. Prominence HealthFirst may arrange, however, to provide access to and treatment for illness or injury. If workers' compensation deems the Member's illness or injury to be non-work related, the Member must go through the workers' compensation appeal process. Before Prominence HealthFirst will consider payment of the claim, Prominence HealthFirst must first receive all final determinations from workers' compensation. The Member must still follow the procedures set forth in this EOC which include, but are not limited to, accessing care through In-Network Practitioners/Providers and obtaining Prior Authorizations.
3. **Other Carrier Continuation of Coverage:** Prominence HealthFirst 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 insurance policy.
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:** In cases when a Member is covered under two insurance contracts which provide similar coverage. Prominence HealthFirst will coordinate benefit payments with the other company. Prominence HealthFirst will pay its benefits if all State-approved guidelines are followed as stated in this EOC which include, but are not limited to, accessing care through In-Network Practitioners/Providers and obtaining Prior Authorizations. Prior to receiving services under Coordination of Benefits, contact the Prominence HealthFirst Member Services Department. One company will provide its full benefit as the primary contract. The other company will be designated as the secondary contract, if necessary, to the extent of its benefit. This prevents double payment and overpayment.

   In order to determine which company is primary, the following rules apply:

   a. If the other contract does not have a provision similar to this one, then it is the primary contract.

   b. If the person receiving the benefit is the Subscriber through which, or to which one contract was issued and is only covered as a Dependent on the other contract, the contract under which the person is the Subscriber shall be primary.

   c. If two or more contracts cover the person receiving care as a Dependent, then the contract of the Subscriber whose birthday, month of birth, follows earliest in the Calendar Year shall be primary unless the other contract uses a rule based on the Subscriber's gender and as a result, the contracts do not agree on the order of benefits. In that case, the other contract shall be primary.

   d. If the Dependent is the child of divorced or separated parents, then benefits for the child are determined in the following order:

      i. First, the plan of the parent with custody of the child;

      ii. Then, the plan of the spouse of the parent with custody of the child;

      iii. Finally, the plan of the parent not having custody of the child; and

      Notwithstanding a., b., and c., above, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which the benefits are actually paid or provided

before the entity has that actual knowledge.

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

f. You are required to cooperate with Prominence HealthFirst 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 HealthFirst will reduce the payments under this EOC by the amount to which You are entitled from that source. In some cases, Prominence HealthFirst 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 HealthFirst.

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

a. 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.

i. **Definitions:**

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

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

03. ESRD - End Stage Renal Disease.

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

ii. **Effect on Benefits:**

If, according to the rules for determining benefits:

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

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

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

002. Then, Prominence HealthFirst benefits are paid.

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

b. **Rules for determining order of benefits:**

i. For the Subscriber or the Eligible Employee – If all the following apply, then Prominence HealthFirst has primary responsibility for Your claims:

01. The Member is age 65 or older;

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

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

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

i. The spouse is age 65 or older;

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

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

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

d. **For a Disabled Person** - Prominence HealthFirst has primary responsibility for the claims of a Member.

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

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

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

01. Who is eligible for Medicare Benefits because of end-stage renal disease; even if he or she is also eligible for Medicare, Parts A and B, because of age; and

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

f. **Prominence HealthFirst has secondary responsibility** - For the claims of a Member who is eligible for secondary Medicare benefits solely because of end-stage renal disease after the coordination period has ended.

g. **Beginning of Coordination Periods:**

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

001. The first month of dialysis; or

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

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

h. **End of Coordination Periods:**

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

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

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

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

iii. The coordination period ends with the earlier of the end of the 18th month of eligibility for or entitlement to Medicare Part A, for individuals who become entitled to, or eligible for Medicare

Part solely on the basis of ESRD from February 1990 through July 1994.

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

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

Part XII. Member Rights and Responsibilities

1. **Confidentiality of Healthcare Records:** Information from Your medical records and information received from Practitioners/Providers incident to the doctor-patient or Hospital-doctor relationship shall be kept confidential. Except for use incident to bona fide medical research and education or reasonably necessary in connection with the administration of the Prominence HealthFirst program, such records may not be disclosed without Your consent.
2. **Primary Care Practitioner (PCP):** Every Prominence HealthFirst Member must have a PCP. You have the right to select, or have selected on Your behalf, a PCP from the Prominence HealthFirst In-Network Practitioner/Provider panel. Your PCP will act as the coordinator and manager of Your healthcare needs. If You do not select a PCP, Prominence HealthFirst will select one for You.
3. **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 Practitioners/Providers in making decisions about Your healthcare. See Section 9 below.
4. **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 HealthFirst coverage and benefits. You are encouraged to contact Member Services at 775.770.9310 or 800.863.7515 with any questions or problems as soon as they arise. Prominence HealthFirst is committed to providing prompt and responsive service to all Members.

   We have established a Member Complaint and Appeal Procedure to assist You if You have a problem or concern regarding any aspect of Prominence HealthFirst services. The Complaint and Appeal Procedure is provided in this Evidence of Coverage and is also available upon request from the Prominence HealthFirst Member Services Department.
5. **Notice of Claim:** You should not have to make payments for Medically Necessary Covered Services to Prominence HealthFirst In-Network Practitioners/Providers except for the required Copayments, Calendar Year Deductible, or Co-Insurance. If, however, You have paid for services which are covered by this EOC, You may be reimbursed providing:
   a. You provide Prominence HealthFirst with satisfactory evidence that You have properly made such a payment.
   b. You make the request for reimbursement within 12 months of the date of service and provide proof of payment. Requests should be submitted to:

      Prominence HealthFirst
      Claims Department
      1510 Meadow Wood Lane
      Reno, Nevada 89502
6. **Healthy Lifestyle:** As a Prominence HealthFirst 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 Practitioners/Providers.
7. **Maintain Appointments:** You have a responsibility to keep the appointment made by or for You with In-Network Practitioners and other Providers of care. If You are unable to keep an appointment, always make an effort to notify the In-Network Practitioner/Provider and cancel at least 24 hours in advance. If You do not show up for a scheduled appointment, You may be financially responsible for the applicable copayment.
8. **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 Practitioners and providers need in order to provide care.

9. **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.
10. **Information:** You have the right to receive information about the organization, its services, Practitioners, Providers and the above rights and responsibilities. To obtain information about Practitioners and Providers who participate with Prominence HealthFirst, You can call Member Services at 775.770.9310 or 800.863.7515, or find this information at www.prominencehealthplan.com. You have the right to make recommendations regarding the organization's Member Rights and Responsibilities policies. The Member has the responsibility to provide, to the extent possible, information that Prominence HealthFirst and its Practitioners/Providers need in order to care for them.
11. **Continuity of Care:** Coverage provided under this section is available until the latest of the following dates:

The 90th day following the date the contract was terminated between the In-Network Practitioner/Provider and Prominence Health Plan; or if the medical condition is pregnancy, the 90th day after the date of delivery or if the pregnancy does not end in delivery the date of the end of the pregnancy.

The Member or Plan Practitioner/Provider can submit a continuity of care request to the company address below. If Prominence Health Plan agrees to the continuity of care request, we will pay for Covered Services at the In-Network Plan Practitioner/Provider level of coverage for a limited time, as specified above.

Address:

Prominence Health Plan
1510 Meadow Wood Lane
Reno, NV 89502

Phone:

(775) 770-9310
1-800-863-7515

12. State of Nevada Division of Insurance

1818 E. College Pkwy., Suite 103
Carson City, Nevada 89706
775.687.0700 or 888.872.3234
Monday – Friday, 8 a.m. – 5 p.m.

Part XIII. General Provisions

1. **Entire Contract:** This EOC, SOB and any Riders purchased by the Individual, the application, and the individual enrollment form, constitute the entire Contract between Prominence HealthFirst, 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 HealthFirst reserves to itself and its designated administrators the exclusive right to interpret or to construe the terms of this Plan, to resolve all questions concerning the status and rights of Members and others under the Plan including, but not limited to, eligibility for benefits and to make any other determinations it deems reasonable in the administration of the Plan.
3. **Assignment:** This contract is not assignable by You without written consent of Prominence HealthFirst. 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 HealthFirst reserves the right to make payment directly to the covered person and to refuse to honor such direction and assignment. No payment by Prominence HealthFirst pursuant to such direction shall be considered recognition by Prominence HealthFirst of a duty or obligation to pay a provider of medical services or supplies except to the extent HealthFirst actually chooses to do so.
4. **Amendment:** Prominence HealthFirst may amend this EOC in accordance with the provisions contained herein.
5. **Litigation for Payment:** You may not sue Prominence HealthFirst for refusing to pay for services unless You start the lawsuit within one year from the date on which the services were provided or requested.
6. **Notice:** When a notice is required under this EOC, it must be mailed to:

   Prominence HealthFirst
   Member Services
   1510 Meadow Wood Lane
   Reno, Nevada 89502

   The notice must also be mailed to the You at the most recent address on file with Prominence HealthFirst. You are required to inform Prominence HealthFirst of any change of address.
7. **Return of Overpayment:** If, due to clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Member, if it is requested, the amount of overpayment will be deducted from future benefits payable.
8. **Information:** Information as to how services may be obtained will be furnished to You upon enrollment and may also be obtained upon request from the Member Services Department.
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 Law.

Part XIV. Service Area

Prominence HealthFirst is currently approved to service the following counties:

Washoe County

Carson City

Clark County

Douglas County

Lyon County

Nye County

Storey County

Part XV. Internal Claims and Appeals Procedures

The following Internal Claims and Appeal Procedures has been developed to assure a timely and appropriate response to a Member's concerns. Additionally, Prominence HealthFirst will take into account the clinical urgency of the situation as it relates to the timeliness of responding to Complaints and Appeals. The Prominence HealthFirst Member Services Department is available between 8 a.m. and 5 p.m. Monday through Friday at 775.770.9310 or 800.863.7515 to assist the Member.

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

1. Definitions

An Adverse Benefit Determination eligible for "internal" claims and appeals processes 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:

- A determination that an individual is not eligible for coverage (e.g., rescission), or
- Denying coverage due to a preexisting condition exclusion, or
- The refusal to pay a claim, in whole or in part, due to the terms of a coverage document regarding co-pays, deductibles, or other cost sharing requirements.

Appeal: A written request to Prominence HealthFirst to change an Adverse Benefit Determination.

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

2. Types of Claims

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

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

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

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

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

a. Prior-Authorization (Pre-Service) Claims

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

If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and You (or Your authorized representative) will have 45 days to

provide the specified information to Prominence HealthFirst after receiving the notice. If all of the needed information is received within the 45-day time frame, Prominence HealthFirst will notify You of the decision within 15 days after the information is received.

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

b. Post-Service claims

Post-Service claims are those claims with respect to which approval prior to receiving medical care is not required or 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 HealthFirst within 30 calendar days after Prominence HealthFirst receives the claim.

c. Concurrent Care Claims

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

d. Urgent Care Claims

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a physician with knowledge of Your health condition, would subject You to severe pain that cannot be adequately managed without the requested services or in the case of a pregnant woman, cause serious jeopardy to the health of the fetus(es). Prominence HealthFirst in consultation with Your treating physician, will decide if the claim is an Urgent Care claim.

Prominence HealthFirst 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 Care claim. However, if necessary information is missing from the claim, Prominence HealthFirst will notify You (or Your authorized representative) after receiving the claim to specify what information is needed. Determinations of Urgent Care claims may be provided orally, followed within three calendar days by written or electronic notification.

3. How to File a Claim

In order to file a claim, a Member must:

a. Either download a copy of the claim form from our website: http://www.prominencehealthplan.com or request a claim form from the Subscriber's employer or from Prominence HealthFirst within 20 days after charges are incurred, or as soon as reasonably possible. Prominence HealthFirst will send the claim form to the Member within 15 days after receiving the request.

Prominence HealthFirst 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 HealthFirst may reasonably require.

4. Where to Send a Claim

Send completed claim forms and the original bills to:

Prominence HealthFirst
1510 Meadow Wood Lane
Reno, Nevada 89502
Telephone: 775.770.9310 / 800.863.7515
Hours of Operation: 8 a.m. - 5 p.m.
Monday - Friday

5. Payment of Claim

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

6. When a Claim is Denied

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

i. A notice of Adverse Benefit Determination will include information sufficient to identify the claim involved, including the date of service, healthcare provider and 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 HealthFirst will provide such codes and corresponding meanings as soon as practicable after receipt such requests. Requests for diagnosis and treatment code(s) and corresponding meaning(s) are merely information requests and will not trigger the start of an internal appeal or external review,

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

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

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

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

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

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

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

Para obtener asistencia en Español, llame al: 775.770.9310 / 800.863.7515. Los avisos están también dis ponibles en Español a petición.

7. Resolving Member Complaints or Claims

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

8. Internal Appeals of Denied Claims.

a. Appealing a Denied Claim for Plan Benefits

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

i. **How to File An Appeal:** To initiate an Appeal, You (or Your authorized representative) must submit a request for an Appeal in writing to Prominence HealthFirst within 180 calendar days after receipt of Your denial notice. Send completed written appeals to: Prominence HealthFirst, 1510 Meadow Wood Lane, Reno, Nevada 89502. Urgent care claims may be appealed orally.

If You have an Urgent Care Claim You want to appeal, or if You have any questions about the appeal process, please call 775.770.9310 / 800.863.7515, Hours of Operation: 8 a.m. – 5 p.m. Monday – Friday. If You believe that Your appeal qualifies as an Urgent Care Claim, You should also inform Prominence HealthFirst that You believe Your appeal should be expedited.

If You fail to Appeal a denial within the 180-day period, Prominence HealthFirst's initial claim determination will be final and binding. If You are physically incapacitated during the Appeal timeline and Your authorized representative was unable to submit the Appeal on Your behalf, then You are entitled to an additional 60 days to submit Your Appeal. Upon request, Prominence HealthFirst will assign an Appeals Specialist to assist You (or Your Representative) through the appeal process.

The Appeal will be reviewed by the Appeals Committee. An Appeals Committee Member's compensation, promotional opportunities or other terms and conditions of employment have no relationship to whether a Member's appeal is granted or denied. If You Appeal, You (or Your authorized representative) may submit comments, documents, records or other information You feel are pertinent to permit the Appeals Committee to re-examine all facts and make a determination with respect to the denial. As a Prominence HealthFirst Member, You may request reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. In addition, You may request reasonable access to all documents submitted on Your behalf to the Appeals Committee.

Upon request, You can obtain a copy of the benefit provisions, guidelines or protocols on which the denial decision was based. The Member or the Member's designated representative may appear in person or by teleconference to present information to the Appeals Committee.

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

b. **Appeal:** Your Appeal will be reviewed and the decision made by someone not involved in the initial denial of Your claim. The Appeals Committee will consult with an appropriate healthcare professional who was not involved in the initial denial of Your claim with respect to Appeals involving medical judgment. The Appeals Committee will not afford deference to the initial claim denial. In the event new or additional evidence is considered, relied on or generated by the Plan or Appeals Committee 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 Committee 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 Committee. The Appeals Committee will provide written or electronic notification of its decision within 30 calendar days after it receives an Appeal for a pre-certification claim or a post-service claim. In the case of an Urgent Care Claim Appeal, Prominence HealthFirst will either respond orally with a decision within 72 hours, followed up by written or electronic notification, or will provide written confirmation of its decision within 72 hours.

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

i. A notice of Adverse Benefit Determination will include information sufficient to identify the claim involved, including the date of service, healthcare 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 HealthFirst will provide such codes and corresponding meanings as soon as practicable after receipt of such requests. Requests for diagnosis and treatment code(s) and corresponding meaning(s) are merely information requests and will not trigger the start of an external review.

ii. The specific reason or reasons for the Adverse Benefit Determination on Appeal,

iii. Reference to the specific Plan provisions upon which the determination is based,

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

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

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

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

viii. A statement of Your right to 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 disponibles en Español a petición.

9. 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 HealthFirst that the claim is denied, have filed a written Appeal in accordance with the Appeal procedure described above; or

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

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

Consumer Health Assistance
555 East Washington Avenue, Suite 4800
Las Vegas, Nevada 89101
t: 702.486.3587 or 888.333.1597
f: 702.486.3586

10. NOTICE OF APPEAL RIGHTS UNDER NEVADA LAW

You have a right to appeal any decision Prominence HealthFirst makes that denies payment on Your claim or Your request for coverage of a healthcare service or treatment.

You may request an additional explanation when Your claim or request for coverage of a healthcare service or treatment is denied or the healthcare service or treatment You received was not fully covered. Contact us at 775.770.9310 or 800.863.7515 when You:

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

or

- Disagree with the denial or the amount not covered and You want to appeal.

If Your claim was denied due to missing or incomplete information, You or Your healthcare 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 HealthFirst Member Services, 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 time frame for completing the expedited review for urgent claims either internally or externally do not apply. Emergency medical conditions are those that would jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.

Review for requests of emergency experimental or investigational medical treatment may be made at the same time a request for an expedited review of a denied claim has been made both internally and externally. If the initial denial of the claim for emergency experimental or investigational treatment involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or investigational and if the Covered Person's treating Practitioner certifies in writing that the recommended or requested healthcare service or treatment (the subject of the initial claim denial) would be significantly less effective if not promptly initiated, then the independent review organization assigned to conduct the expedited external review will decide whether the Covered Person will be required to complete the expedited review of the denied claim before medical services are provided.

11. External Review of Denied Claims

External Review: If Prominence HealthFirst 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 Nevada 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.

12. Standard External Review

a. The Member may submit a request for an External Review of an adverse determination under this section only after the Member has exhausted all applicable internal Prominence HealthFirst Appeals Procedures provided under this Plan and if Prominence HealthFirst 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 HealthFirst agrees to permit the Member to submit the adverse determination to OCHA without requiring the Member to exhaust all internal Prominence HealthFirst Appeals Procedures. In such event, the Member shall be considered to have exhausted the applicable internal Prominence HealthFirst Appeals Process.

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

c. Within five (5) days after receiving notification specifying the assigned IRO from OCHA, Prominence HealthFirst shall provide to the selected IRO all documents and materials relating to the adverse determination, including, without limitation:

i. Any medical records of the Member relating to the adverse determination;

ii. A copy of the provisions of the healthcare Plan upon which the adverse determination was based;

iii. Any documents used and the reason(s) given by Prominence HealthFirst's Managed Care Program for the adverse determination; and

iv. 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 determination.

Within five (5) days after the IRO receives the required documentation from Prominence HealthFirst, 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 HealthFirst within one (1) business day after receipt. The IRO shall approve, modify, or reverse the adverse 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:

v. Member;

vi. Member's Physician;

vii. Member's Authorized Representative, if any; and

viii. Prominence HealthFirst

Expedited External Review

d. A request for an Expedited External Review may be submitted to OCHA after it receives proof from the Member's Provider that the adverse 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.

The 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

HealthFirst will supply all relevant medical documents and information used to establish the adverse determination to the IRO within twenty-four (24) hours after receiving notice from the OCHA. 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 HealthFirst agree to a longer time period.

The IRO shall notify the following parties no later than twenty-four (24) hours after completing its Expedited External Review:

v. Member;

vi. Member's Physician;

vii. Member's Authorized Representative, if any; and

viii. Prominence HealthFirst

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

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

e. A Standard or Expedited External Review of an adverse 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.

Standard External Review

f. The Member or Member's Authorized Representative may, within four (4) months after receiving notice of an adverse determination subject to this section, submit a request to the OCHA for an External Review.

g. OCHA will notify Prominence HealthFirst 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 HealthFirst receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, Prominence HealthFirst will make a preliminary determination of whether the case is complete and eligible for External Review.

h. Within one (1) business day of making such a determination, Prominence HealthFirst will notify in writing, the Member or the Member's Authorized Representative and OCHA, accordingly. If Prominence HealthFirst determines that the case is incomplete and/or ineligible, Prominence HealthFirst 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 also state that such determination may be appealed to OCHA. Upon appeal, OCHA may overturn Prominence HealthFirst's determination that a request for External Review of an adverse determination is ineligible, and submit the request to External Review, subject to all of the terms and provisions of this Plan and applicable Nevada law and regulation.

i. Within one (1) business day after receiving the confirmation of eligibility for External Review from Prominence HealthFirst, OCHA will assign the IRO accordingly and notify in writing the Member or the Member's Authorized Representative and Prominence HealthFirst that the request is complete and eligible for External Review and provide the name of the assigned IRO. Prominence HealthFirst, within five (5) days after receipt of such notice from the OCHA, will supply all relevant medical documents and information used to establish the adverse determination to the assigned IRO who will select and assign one or more clinical reviewers to the External Review.

j. The IRO shall approve, modify, or reverse the adverse determination pursuant to this section within twenty (20) days after it receives the information required to make such a determination. The Independent Review Organization shall submit a copy of its determination, including the basis thereof, to the:

i. Member;

ii. Member's Physician;

iii. Member's Authorized Representative, if any; and

iv. Prominence HealthFirst

Expedited External Review

k. The Member or the Member's Authorized Representative may request in writing, an internal Expedited Appeal by Prominence HealthFirst and an Expedited External Review from OCHA simultaneously if the adverse determination of the requested or recommended service or treatment is determined by Prominence HealthFirst 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.

l. An oral request for an Expedited External Review may be submitted directly to the 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, the OCHA shall immediately notify Prominence HealthFirst accordingly.

m. Prominence HealthFirst 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 the OCHA of the determination. If Prominence HealthFirst determines the request to be ineligible, the Member will be notified that the request may be appealed to OCHA.

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

o. 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 HealthFirst by the IRO within one (1) business day.

p. 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:

i. Member;

ii. Member's Physician;

iii. Member's Authorized Representative, if any; and

iv. Prominence HealthFirst

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

Office for Consumer Health Assistance

702.486.3587 in the Las Vegas area 1.888.333.1597 / outside the Las Vegas area (toll free)

Part XVI. 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:

Scott Heinze - Privacy Officer
Prominence HealthFirst
1510 Meadow Wood Lane
Reno, Nevada 89502
t: 775.770.9444
f: 775.770.9360

WHO WE ARE

This Privacy Notice (the "Privacy Notice") describes the privacy practices of Prominence HealthFirst and applies to any health services You receive through the Prominence HealthFirst.

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 HealthFirst to notify participants and beneficiaries about the policies and practices Prominence HealthFirst has adopted to protect the confidentiality of their health information, including healthcare payment information.

This Privacy Notice describes the privacy policies of Prominence HealthFirst. These policies protect medical information relating to Your past, present and future medical conditions, healthcare treatment and payment for that treatment and payment for that treatment (Protected Health Information or PHI).

This law requires Prominence HealthFirst to maintain the privacy of Your PHI, to provide You with this Privacy Notice of its legal duties and privacy practices, and to abide by the terms of this Notice. In general, Prominence HealthFirst 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 PROMINENCE HEALTHFIRST MUST DISCLOSE YOUR PHI

Prominence HealthFirst 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 HealthFirst 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.

WHEN PROMINENCE HEALTHFIRST MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

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

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

1. **For Treatment.** Prominence HealthFirst does not provide medical treatment directly, but it may disclose Your PHI to a healthcare provider who is giving treatment. For example, Prominence HealthFirst may disclose the types of prescription drugs You currently take to an emergency room Practitioner, 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.

2. **For Payment.** Prominence HealthFirst may use and disclose PHI, as needed, to pay for Your medical benefits. For example, Prominence HealthFirst may tell a doctor whether You are eligible for coverage or what percentage of the bill Prominence HealthFirst might pay. Prominence HealthFirst 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 Prominence HealthFirst, including Medicare, or Medicaid, and to do utilization review and pre-authorizations.

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

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

5. **To Your Other Healthcare Providers.** We may also share PHI with Your doctor and other healthcare providers when they need it to provide Treatment to You, to obtain Payment for the care they give to You, to perform certain Healthcare Operations, such as reviewing the quality and skill of healthcare professionals, or to review their actions in following the law.

6. **To Business Associates.** Prominence HealthFirst may hire third parties that may need Your PHI to perform certain services on behalf of the Prominence HealthFirst. These third parties are "Business Associates" of the Plan. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, Prominence HealthFirst. For example, Prominence HealthFirst 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.

7. **To Individuals Involved with Your Care or Payment for Your Care.** Prominence HealthFirst 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 HealthFirst to do so; 2) Prominence HealthFirst informs You that it intends to do so and You do not object; or 3) Prominence HealthFirst infers from the circumstances, based upon professional judgment, that You do not object to the disclosure. Whenever possible, Prominence HealthFirst 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.

8. **To Personal Representatives.** Prominence HealthFirst may disclose Your PHI to someone who is Your personal representative. Before Prominence HealthFirst 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 HealthFirst may not disclose certain information to the parents. Prominence HealthFirst may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.

9. **For Treatment Alternatives or Health-Related Benefits and Services.** Prominence HealthFirst may contact You to provide information about treatment alternative or other health-related benefits or services that may be of interest to You.

10. **For Public Health Purposes.** Prominence HealthFirst may:

    a. Report specific disease or birth/death information to a public health authority authorized to collect that information;

    b. Report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;

        i. 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

        ii. 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.

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

12. **For Health Oversight Activities.** Prominence HealthFirst 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 healthcare system or to monitor government benefit programs.

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

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

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

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

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

18. **To Avert Serious and Imminent Threats to Health or Safety.** Prominence HealthFirst may disclose PHI to avert a serious and Imminent threat to Your health or safety or that of Members of the public.

19. **For Special Governmental Functions.** Prominence HealthFirst 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.

20. **For Workers' Compensation.** Prominence HealthFirst may disclose PHI for workers' compensation if necessary to comply with these laws.

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

22. **For Emergencies and Disaster Relief.** Prominence HealthFirst may disclose PHI to organizations engaged in emergency and disaster relief efforts.

23. **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 HealthFirst 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 HealthFirst 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 You cancellation will interfere with the insurer's right to contest Your claims for benefits under the insurance policy. Prominence HealthFirst 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 HealthFirst 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 disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; (9) about sexual assault; or (10) 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, or care coordination, or alternative treatments, therapies, healthcare providers, or care settings without Your permission. For example, we may not sell Your PHI without Your written authorization.

Your Individual Rights. You have certain rights under the Privacy Rules relating to Your PHI maintained by Prominence HealthFirst. All requests to exercise those rights must be made in writing to the Privacy Officer. Prominence HealthFirst's insurers and HMO's keep their own records and You must make Your requests relating to You PHI in those records directly to that insurer or HMO. Your rights are: Right to Request Restrictions on Uses and Disclosures of Your PHI. You may request that Prominence HealthFirst restrict any of the permitted uses and disclosures of Your PHI listed above. Prominence HealthFirst, however, does not always have to agree to Your requested restriction. A restriction cannot prevent use or disclosures that are required by the Secretary of DHHS to determine or investigate Prominence HealthFirst's compliance with the Privacy Rules, or that are otherwise required by law. We must grant Your request to a restriction on disclosure of Your PHI to a health plan if You have paid for the healthcare item in full out of pocket.

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

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

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

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

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

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

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

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 HealthFirst's Privacy Officer or with the Secretary of the DHHS. Prominence HealthFirst 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 or HMO, You may file a complaint with the individual named in their Notice of Privacy Practices to receive complaints. If Your complaint is with Prominence HealthFirst, You may submit Your complaint to the Privacy Officer at the address at the end of this 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 Office can provide You the address. He will not take any action against You for filing a complaint. To file a complaint with the Secretary of the DHHS, You must submit Your 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 Notice upon Request. You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of the Notice, contact the Prominence HealthFirst Privacy Official.

Health Information not Covered by this notice.

This 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 the Company can have under applicable law e.g., the Family and Medical Leave Act, the Americans with Disabilities Act, worker's compensation, federal and state occupational health and safety laws, and other state and federal laws), or that the Company properly can get for employment related purposes through sources other than Prominence HealthFirst 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 Notice. Prominence HealthFirst reserves the right to change the terms of this Notice to make the new revised Notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by Prominence HealthFirst before the date of the revised Notice. If You agree, Prominence HealthFirst may provide You with a revised Notice electronically. Otherwise, Prominence HealthFirst will provide You with a paper copy of the revised Notice. In addition, Prominence HealthFirst will post the revised Notice on its website used to provide information about Prominence HealthFirst's benefits.

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

To file a complaint with Prominence HealthFirst, You must submit Your complaint in writing to:

Scott Heinze - Privacy Officer
Prominence HealthFirst
1510 Meadow Wood Lane
Reno, Nevada 89502
t: 775.770.9444
f: 775.770.9360

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

Michael Kruley, Regional Manager
Office for Civil Rights (Region IX - Nevada)
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
t: 415.437.8310
f: 415.437.8329

To file a 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, Nevada 89101
t: 702.486.3587 or 888.333.1597