HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

P.O. Box 15645
Las Vegas, Nevada 89114-5645

MyHPN Agreement of Coverage

A Qualified Health Plan (QHP)

This Plan may include a Calendar Year Deductible; please refer to the Attachment A, Benefit Schedule.

This Agreement of Coverage (AOC) describes your healthcare plan.

Health Plan of Nevada, Inc. (HPN), and the Subscriber have agreed to all of the terms of this AOC. It is part of the contract between HPN and the Subscriber. This Plan is guaranteed renewable. It may be terminated by HPN or the Subscriber with written notice.

This AOC tells you about your benefits, rights and duties as an HPN Member. It also tells you about HPN's duties to you. This AOC including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, your Enrollment Form, health statements, Member Identification Card and all other applications received by HPN are all part of your HPN membership package. Please read them carefully and keep them in a safe place. **Words that are capitalized are defined in Section 12 – Glossary.**

Table of Contents

SECTION 1. Eligibility, Enrollment and Effective Date ... 4

SECTION 2. Termination ... 6

SECTION 3. Managed Care ... 6

SECTION 4. Obtaining Covered Services ... 7

SECTION 5. Covered Services ... 8

SECTION 6. Exclusions ... 16

SECTION 7. Limitations ... 19

SECTION 8. Coordination of Benefits (COB) ... 19

SECTION 9. Premium Payments, Grace Period and Changes in Premium Rates ... 21

SECTION 10. General Provisions ... 21

SECTION 11. Appeals Procedures ... 25

SECTION 12. Glossary ... 28

Attachment A Benefit Schedule

Attachment B Service Area

Endorsements, if applicable

Riders, if applicable

The Department of Business and Industry

State of Nevada

Division Of Insurance

Telephone Numbers for Consumers of Healthcare

The Division of Insurance ("Division") has established a telephone service to receive inquiries and complaints from consumers of healthcare in Nevada concerning healthcare plans.

Hours of operation for the Division:

Monday through Friday from 8 a.m. until 5 p.m., Pacific Standard Time (PST)
The Division is closed during state holidays.

Contact information for the Division:

Carson City Office:
Phone: (775) 687-0700
Fax: (775) 687-0787
1818 East College Pkwy., Suite 103
Carson City, NV 89706

Las Vegas Office:
Phone: (702) 486-4009
Fax: (702) 486-4007
2501 East Sahara Ave., Suite 302
Las Vegas, NV 89104

The Division also provides a toll-free number for consumers residing outside of the above areas:

1-800-992-0900 Please listen to the greeting and select the appropriate prompt.

If you have any questions regarding eligibility or termination, please contact the Federally Facilitated Marketplace at:

www.healthcare.gov or

1-800-318-2596

If you have any questions regarding your health care coverage, please contact HPN's Member Services Department at the following:

Address:

Health Plan of Nevada, Inc.
Attn: Member Services Department
P.O. Box 15645
Las Vegas, NV 89114-5645

Phone:

English

(702) 838-8294 or 1-877-752-8026

(Monday – Friday from 8:00 a.m. until 5:00 p.m., Pacific Standard Time):

Español

702-242-3062 or 1-877-512-9339

(De lunes a viernes de 8:00 a.m. a 5:00 p.m., Hora del Pacífico)

Agreement of Coverage

SECTION 1. Eligibility, Enrollment and Effective Date

Subscribers and Dependents who meet the following criteria are eligible for coverage under this Plan.

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an Individual must:

- Live in HPN's Service Area.
- Meet the guidelines established in the HPN Enrollment Application Form.
- Complete and submit to HPN such Enrollment Applications or forms that HPN may reasonably request.
- Be a United States citizen or national.

Dependent. To be eligible to enroll as a Dependent, an individual must be one of the following:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage;
- A registered Domestic Partner;
- A child by birth. Adopted child. Stepchild. Minor child for whom a court has ordered coverage. Child being Placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian;, or
- Meet the guidelines established in the HPN Enrollment Application Form.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under the limiting age of 26.
- A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.
- A Dependent includes a Dependent child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below:
    a. The child must be covered as a Dependent under this Plan before reaching the limiting age, and proof of incapacity and dependency must be given to HPN by the Subscriber within sixty (60) days of the child reaching the limiting age; or

    b. The handicap started before the child reached the limiting age, but the Subscriber was covered by another health insurance carrier that covered the child as a handicapped Dependent prior to the Subscriber applying for coverage with HPN.

Evidence of any Court Order needed to prove eligibility must be given to the Federally Facilitated Marketplace.

1.2 Who Is Not Eligible

The following individuals are not eligible for coverage:

- An individual who is eligible and/or enrolled for coverage under Medicare Part A and/or B at the time of application.
- A foster child of the applicant or Subscriber.
- A child placed in the applicant or Subscriber's home other than for adoption.
- A grandchild of the applicant or Subscriber.
- An incarcerated individual (in prison; does not apply if you are waiting for disposition of charges).
- Any other person not defined in Section 1.1.

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give the Federally Facilitated Marketplace written notice within fourteen (14) days of changes which affect his Dependents' eligibility. Changes include, but are not limited to:

- Reaching the limiting age
- Ceasing to satisfy the mental or physical handicap requirements.
- Death.
- Divorce.
- Transfer of residence outside HPN's Service Area.
- The Eligible Person and/or Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if HPN receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.
- Any other event which affects a Dependent's eligibility.

If the Subscriber fails to give notice which would have resulted in termination of coverage, HPN shall have the right to appeal eligibility through the Federally Facilitated Marketplace to terminate coverage.

A Dependent's coverage terminates on the same day as the Subscriber.

Continuation of Coverage Due to Specific Change in Eligibility Status.

A Member that becomes ineligible for coverage under this Plan due to specific changes in eligibility status may qualify for the same rates and coverage under their current HPN Health Benefit Plan under the following circumstances:

- Death of the Subscriber;
- Divorce between Subscriber and spouse; or
- When a child involuntarily fails to meet the eligibility rules outlined in Section 1.1.

In order to qualify for continuation of coverage under the above circumstances, the affected Member must contact the Federally Facilitated Marketplace within sixty (60) days of the date of

loss of eligibility to request continued coverage. Any and all waiting periods satisfied under the current Plan will be credited to the Member under the continued Plan coverage.

Special Eligibility Standards and Process for Indians.
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. The Federally Facilitated Marketplace 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 the Federally Facilitated Marketplace 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 your plan selection, all of your plan accumulators such as deductibles and out of pocket maximums will be reset under the new plan.

1.4 Application

Eligible Individuals and Eligible Family Members must make application to the Federally Facilitated Marketplace in order to have coverage under this Plan.

1. **Newly Eligible Family Members.** Any Individual becoming newly eligible as a Dependent may apply for coverage under an HPN Plan by submitting to the Federally Facilitated Marketplace the Enrollment Application Form or Membership Change Form within sixty (60) days of the date on which the individual becomes eligible. A person may become a Newly Eligible Family Member as the result of:
   - A change in the Subscriber's marital status.
   - A birth or adoption of a child by the Subscriber.
   - Loss of eligibility with other healthcare coverage.

   Enrollment must take place within sixty (60) days of the date of initial eligibility under the circumstances listed above.

2. **Right to Deny Application.** The Federally Facilitated Marketplace can deny membership to any person who:
   - At application, does not meet the applicable eligibility guidelines.
   - Fails to make a premium payment.
   - Misrepresents and/or fails to disclose a material fact which would affect coverage under this Plan.

3. **Annual Open Enrollment Periods**. The Federally Facilitated Marketplace provides an annual open enrollment period, during which you may enroll in a QHP or change QHPs, if eligible. Please refer to the Federally Facilitated Marketplace website: www.healthcare.gov for open enrollment dates. You are only permitted to change QHPs during the annual open enrollment period or a special enrollment period for which you have been found eligible.

   You may change your QHP selection during the annual open enrollment period.

1.5 Effective Date of Coverage

Before coverage can become effective, HPN must receive and accept premium payments and an Enrollment Application Form for the person applying to be a Member or the Enrollment Application from the Federally Facilitated Marketplace or its designee.

1. When the Enrollment Application Form is received, approved and applicable premium payments have been accepted by HPN the Effective Date is as follows:
   Open Enrollment (2016) -The annual open enrollment period is November 1, 2015 through January 31, 2016.
   - Applications received between November 1, 2015 and December 15, 2015 will be effective January 1, 2016.
   - Applications received between December 16, 2015 and January 15, 2016 will be effective February 1, 2016.
   - Applications received between January 16, 2016 and January 31, 2016 will be effective March 1, 2016.

2. Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber makes application for the child as a Dependent and pays the premium within sixty (60) days of the date of birth.

3. An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child's birth. A child Placed for Adoption at any other age is covered for the first thirty-one (31) days following the Placement for Adoption.

   Coverage continues after the applicable thirty-one (31) day period only if the Subscriber makes application for the child as a Dependent and pays the premium within sixty (60) days after the placement of the child in the Subscriber's home or the child's birth. The coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.

4. If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31)) days if the Subscriber makes application for the Dependent and pays the Dependent's premium. A copy of the court order must be given to the Federally Facilitated Marketplace.

Subscriber must give the Federally Facilitated Marketplace a copy of the certified birth certificate, decree of adoption, or certificate of Placement for Adoption for coverage to continue after thirty-one (31) days for newborn and adopted children.

Subscriber must give the Federally Facilitated Marketplace a copy of the certified marriage certificate or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. Termination

HPN may terminate coverage under this Plan at the times shown for any one or more of the following reasons:

2.1 Termination by HPN

- Failure to maintain eligibility requirements as set forth in Section 1.
- If the Subscriber does not receive an advanced premium tax credit and the Subscriber fails to make premium payments within one (1) month of the premium due date, coverage will be terminated on the first day of the month for which a premium was due and not received by or HPN.
- If the Subscriber receives an advance premium tax credit and the Subscriber fails to make premium payments within the three (3) month grace period of the premium due date, coverage will be terminate on the last day of the first month of the three (3) month grace period after the premium due was not received by the Federally Facilitated Marketplace or HPN.
- With sixty (60) days written notice, if the Member allows his or any other Member's HPN ID Card to be used by any other person, or uses another person's ID Card. The Member will be liable to HPN for all costs incurred as a result of the misuse of the HPN Member ID Card.
- The Member performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, HPN has the right to appeal to the Federally Facilitated Marketplace to rescind coverage and declare coverage under the Plan null and void as of the original Effective Date of Coverage and refund any applicable premium. Sixty (60) days written notice shall be provided to the Member prior to any rescission of coverage. The Member has the right to appeal any such rescission.
- Except as specifically provided in Section 1.3, on the last day of the calendar month in which a Member no longer meets the requirements of Section 1.
- If the Member fails to give written notice within sixty (60) days of the loss of eligibility, HPN can appeal through the Federally Facilitated Marketplace to terminate coverage retroactively and refund any corresponding premium.
- On the 61st day after a change in residence if a Member moves his primary residence outside HPN's Service Area. During the sixty (60) consecutive day period after the change in residence, the only Covered Services that HPN will provide outside HPN's Service Area are Emergency Services and Urgently Needed Services.
- When a Subscriber moves his primary residence outside HPN's Service Area or when a Dependent moves his primary residence outside HPN's Service Area, Subscriber must notify the Federally Facilitated Marketplace within sixty (60) days of the change.

2.2 Termination by the Subscriber

The Subscriber has the right to terminate coverage under the plan by disenrolling through the Federally Facilitated Market Place at www.healthcare.gov or by calling 1-800-318-2596. For additional instructions you can visit https://www.healthcare.gov/reporting-changes/cancel-plan/.

2.4 Effect of Termination

If the Subscriber does not receive an advanced premium tax credit, no benefits will be paid under this plan by HPN for services provider after termination of a Member's coverage. You will be responsible for payment of medical services and supplies incurred after the effective date of the termination of this plan.

If the Subscriber receives an advance premium tax credit, no benefits will be paid under this plan by HPN for services provider after the termination of a Member's coverage. You will be responsible for payment of medical services and supplies incurred after the effective date of the termination of this plan. The date of member's termination for non-payment of premium is the last day of the first month of the three (3) month grace period after the premium was due and not paid.

SECTION 3. Managed Care

This section tells you about HPN's Managed Care Program and which Covered Services require Prior Authorization.

3.1 Managed Care Program

HPN's Managed Care Program, using the services of professional medical peer review committees, utilization review committees, and/or the Medical Director, determines whether services and supplies are Medically Necessary. HPN's Managed Care Program helps direct the patient to the most appropriate setting to provide healthcare in a cost-effective manner.

3.2 Managed Care Program Requirements

HPN's Managed Care Program requires the Member, Plan Providers and HPN to work together.

- All Plan Providers have agreed to participate in HPN's Managed Care Program. Plan Providers have agreed to accept HPN's Reimbursement Schedule amount as payment in full for Covered Services, less the Member's payment of any applicable Copayment, Deductible or Coinsurance amount, whereas Non-Plan Providers have not. Members enrolled under HPN's HMO Plans who use the services of Non-Plan Providers will receive no benefit payments or reimbursement for amounts for any Covered Service, except in the case of Emergency Services or Urgently Needed Services as defined in this AOC, or other Covered Services provided by a Non-Plan Provider that are Prior Authorized by HPN's Managed Care Program including any Prior Authorized Covered Services obtained from a Non-Plan outpatient facility, such as a laboratory, radiological facility (x-ray), or any complex diagnostic or therapeutic services. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.
- It is the Member's responsibility to verify that a Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of HPN's Managed Care Program.

- Compliance by the Member with HPN's Managed Care Program is mandatory. Failure by the Member to comply with the rules of HPN's Managed Care Program means the Member will be responsible for costs of services received.

3.3 Managed Care Process

The Medical Director and/or HPN's Utilization Review Committee will review proposed services and supplies to be received by a Member to determine:

- If the services are Medically Necessary and/or appropriate.
- The appropriateness of the proposed setting.
- The required duration of treatment or admission.

Following review, HPN will complete the Prior Authorization form and send a copy to the Provider and the Member. The form will specify approved services and supplies. **Prior Authorization is not a guarantee of payment.**

The final decision as to whether any care should be received is between the Member and the Provider. If HPN denies a request by a Member and/or Provider for Prior Authorization of a service or supply, the Member or Provider may appeal the denial to the Grievance Review Committee (see Section 11, Appeals Procedures).

3.4 Services Requiring Prior Authorization

All Covered Services not provided by the Member's PCP require written Prior Authorization from the PCP and HPN's Managed Care Program. The following Covered Services require Prior Authorization and review through HPN's Managed Care Program:

- Non-emergency Inpatient admissions and extensions of stay beyond the original certified length of stay in a Hospital, Skilled Nursing Facility or Hospice.
- All outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.
- Severe Mental Illness, Mental Health and Substance Abuse Services.
- All Specialist visits or consultations.
- Prosthetic Devices and Orthotic Devices.
- Courses of treatment, including but not limited to allergy testing or treatment (e.g., skin, RAST); angioplasty; anti-cancer drug therapy; dialysis; physiotherapy or Manual Manipulation; or habilitative services and rehabilitation therapy (physical, speech, occupational).

3.5 Emergency Admission Notification

The Member must report all emergency admissions to the Member Services Department within 24 hours of admission or as soon as reasonably possible to authorize continued care by calling 1-877-752-8026 (English) or 1-877-512-9339 (Español)

All emergency admissions are reviewed Retrospectively to determine if the treatment received was Medically Necessary and appropriate and was for Emergency Services as defined in this AOC. If such Emergency Services are provided by Non-Plan Providers, all Medically Necessary professional, Inpatient or outpatient Emergency Services will be Covered Services.

3.6 Independent Medical Review; Appeals Rights

HPN may require a Member to have an Independent Medical Review prior to issuing Prior Authorization for any medical benefits. In that case, only a Physician or Chiropractor who is certified to practice in the same field of practice as the primary treating Physician or Chiropractor or who is formally educated in that field will conduct the review.

The Independent Medical Review will include a physical exam of the Member and a personal review of all x-rays and reports made by the primary treating Physician or Chiropractor. A certified copy of all reports of findings will be sent to the primary treating Physician or Chiropractor and the Member within ten (10) working days after the review.

If the Member disagrees with the findings of the review, he may submit an appeal for binding arbitration to HPN within thirty (30) days after he receives the report.

The arbiter will be selected by mutual agreement of HPN and the Member. The cost and expense for filing arbitration shall be paid by the party initiating the demand for arbitration. The arbiter may award arbitration fees, expenses, and compensation in an equitable fashion, in favor of any party. The decision of the arbiter shall be binding upon the Member and HPN, and the arbiter's ruling shall be enforceable pursuant to state law.

Please refer to Section 11, Appeals Procedures in this AOC for more information.

3.7 Appeals Rights

All decisions of HPN's Managed Care Program may be appealed by the Member through the Appeals Procedure. If an imminent and serious threat to the health of the Member exists, the appeal will be directed to HPN's Medical Director.

SECTION 4. Obtaining Covered Services

This section tells you under what conditions services are available under this Plan and your obligations as a Member. You should also carefully review the Exclusions and Limitations Sections (Section 6 and Section 7 respectively) prior to obtaining any healthcare services.

4.1 Availability of Covered Services

Members are entitled to receive the Covered Services set forth in Section 5 and the Attachment A Benefit Schedule subject to all terms and conditions of this AOC, and payment of required premium. These Covered Services are available only if and to the extent that they are:

(a) Provided, prescribed or arranged by the Member's Primary Care Physician (PCP);
(b) Specifically authorized through HPN's Managed Care Program;
(c) Received in HPN's Service Area, through a Plan Provider; and
(d) Medically Necessary as defined in this AOC.

This section does not apply to Emergency Services or Urgently Needed Services as defined in this AOC, or other Covered Services provided by a Non-Plan Provider which have otherwise been approved by HPN's Managed Care Program.

4.2 Agreement of Member

Each Member entitled to receive Covered Services under this Plan agrees to:

- Choose a PCP from the list of available PCPs. The Subscriber and each Dependent may select a different PCP.
- A female Member may choose two (2) PCPs: A general practice Physician and an Obstetrician or Gynecological Physician. Members may receive benefits only as provided by or approved in advance by the chosen PCP.
- Receive specialty consultation and/or treatment from Plan Physicians only upon written Prior Authorization according to HPN's Managed Care Program.
- Obtain Prior Authorization from HPN's Managed Care Program before receiving any non-Emergency Services from Non-Plan Providers.
- Be financially responsible for the cost of services in excess of EME when these services are approved by HPN's Managed Care Program and received outside of HPN's Service Area or from Non-Plan Providers.
- Except in the case of Emergency Services and Urgently Needed Services be fully responsible for the cost of services not provided by the PCP according to HPN's Managed Care Program or Prior Authorized by the PCP or HPN's Managed Care Program.
- Provide at least twenty-four (24) hours prior notice of cancellation of an appointment with a Provider.
- Make timely payment of Copayment amounts due to Providers.

4.3 Continuity of Care from Plan Providers

Termination of a Plan Provider's contract will not release the Provider from treating a Member, except for reasons of medical incompetence or professional misconduct as determined by HPN.

Coverage provided under this section is available until the latest of the following dates:

- The 120th day following the date the contract was terminated between the Provider and HPN; or
- If the medical condition is pregnancy, the 45th 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 Provider may submit a request for continuity of care to the address shown below. If the Plan agrees to the continued treatment, the Plan will pay for Covered Services at the Plan Provider level of benefits for a limited time, as outlined above. The Plan Provider may not seek payment from the Member for any amounts for which the Member would not be responsible if the Provider were still a Plan Provider.

Address:

Health Plan of Nevada, Inc.
Attn: Provider Services Dept.
P.O. Box 15645
Las Vegas, NV 89114-5645

Phone:

1-877-752-8026 (English)
1-877-512-9339 (Español)

SECTION 5. Covered Services

This section tells you what services and supplies are covered under this Plan. Only services and supplies, which meet HPN's definition of Medically Necessary will be considered to be Covered Services. The Attachment A Benefit Schedule shows applicable Copayments and benefit limitations for Covered Services. All Covered Services are subject to HPN's Managed Care Program.

5.1 Healthcare Facility Services

Covered Services include the following accommodations, services and supplies received during an admission to a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility or Hospice Care Facility.

Accommodations:

- Semiprivate (or multibed unit) room, including bed, board, and general nursing care.
- Private room including bed, board, and general nursing care, but only when treatment of the Member's condition requires a private room. The semiprivate room rate will be allowed toward the private room rate when a Member receives private room accommodations for any reason other than Medical Necessity.
- Inpatient accommodations provided in connection with the birth of a child shall be provided for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery or a minimum of ninety-six (96) hours following an uncomplicated delivery by cesarean section. This provision does not require a Member to deliver in a Hospital or other healthcare facility or to remain therein for the minimum number of hours following delivery.
- Intensive care unit (including Cardiac Care Unit), including bed, board, general and special nursing care, and ICU equipment.
- Observation unit, including bed, board, and general nursing care not to exceed twenty-three (23) hours.
- Nursery charges for newborns. Reimbursement for Covered Services provided by a Non-Plan Provider outside

HPN's Service Area to a newborn natural child or adopted child is limited to HPN's Eligible Medical Expense for similar Covered Services provided in HPN's Service Area.

Services and Supplies. Covered Services and supplies provided by a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility, or Hospice Care Facility include:

- operating, recovery, and treatment rooms and equipment (Hospital and Ambulatory Surgical Facility only);
- delivery and labor rooms and equipment (Hospital and Ambulatory Surgical Facility only);
- anesthesia materials and anesthesia administration by Hospital staff (Hospital and Ambulatory Surgical Facility only);
- clinical pathology and laboratory services and supplies;
- services and supplies for diagnostic tests required to diagnose Member's Illness, Injury or other conditions but only when charges for the services and/or supplies are made by the facility (Hospital, Skilled Nursing Facility and Ambulatory Surgical Facility only);
- drugs consumed at the time and place dispensed which have been approved for general marketing in the United States by the Food and Drug Administration (FDA);
- dressings, splints, casts and other supplies for medical treatment provided by the Hospital from a central sterile supply department;
- oxygen and its administration;
- non-replaced blood, blood plasma, blood derivatives, and their administration and processing;
- intravenous injections and solutions;
- private duty nursing;
- supportive 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 (Hospice Care Facility only); and
- Sterilization procedures.

5.2 Medical – Physician Services

Covered Services include services which are generally recognized and accepted non-surgical procedures for diagnosing or treating an Illness or Injury, performed by a Plan Provider in his office, the patient's home, or a licensed healthcare facility. Medical Services include:

- direct physical examination of the patient;
- examination of some aspect of the patient by means of pathology laboratory or electronic monitoring procedure which is a generally recognized and accepted procedure for diagnostic or therapeutic purposes in the treatment of an Illness or Injury;
- procedures for prescribing or administering medical treatment;
- treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints, subject to the maximum benefit limitation;
- anesthesia services;
- Manual Manipulation (except for reductions of fractures or dislocations);
- Family planning services including sterilization procedures; and
- Limited diagnostic and therapeutic infertility services determined to be Medically Necessary by HPN and Prior Authorized by HPN's Managed Care Program. Covered Services do not include those services specifically excluded in the Exclusions section herein, but do include limited:
  - Laboratory studies
  - Diagnostic procedures
  - Artificial insemination services, up to six (6) cycles per Member per lifetime.

5.3 Medical – Physician Consultations

Covered Services include medical services rendered by a Plan Specialist or other duly licensed Plan Provider whose opinion or advice is requested by a Member's PCP or the Medical Director for further evaluation of an Illness or Injury on an Inpatient or outpatient basis.

5.4 Preventive Healthcare Services

Covered Preventive Healthcare Services will be paid at 100% of Eligible Medical Expenses, without application of any Copayment, and/or Calendar Year Deductible and Coinsurance when such services are provided by a Plan Provider**.**

For a complete list of Preventive Services, including all FDA approved contraceptives, go to http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/.

5.5 Laboratory Services

Covered Services include prescribed diagnostic clinical and anatomic pathological laboratory services and materials when authorized by a Member's PCP and HPN's Managed Care Program.

5.6 Routine Radiological and Non-Radiological Diagnostic Imaging Services

Covered Services include prescribed routine diagnostic radiological and non-radiological diagnostic imaging services and materials, including general radiography, fluoroscopy, mammography, and sonography, when authorized by a Member's PCP and HPN's Managed Care Program, but only when no charges are made for the same services and/or supplies by a Hospital, Skilled Nursing Facility, or an Ambulatory Surgery Center.

5.7 Emergency or Urgently Needed Services

Emergency Services obtained from Non-Plan providers will be payable at the same benefit level as would be applied to care received from Plan Providers.

Benefits are limited to Eligible Medical Expenses for Non-Plan Provider Emergency Services as defined under "HPN

Reimbursement Schedule". You are responsible for any Non-Plan Provider Emergency Service charges that exceed payments made by HPN.

Benefits for Emergency Services are subject to any limit shown in the Attachment A Benefits Schedule.

IMPORTANT NOTE: No benefits are payable for treatment received by a Member in a Hospital emergency room or other emergency facility for a condition other than an Emergency Service as defined in this AOC. Examples of conditions which require Medically Necessary treatment, but not Emergency Services, include:

- Sore throats.
- Flu or fever.
- Earaches.
- Sore or stiff muscles.
- Sprains, strains or minor cuts.
- Suture removal.
- Routine dental services.
- Medication refills.

(a) **Within the HPN Service Area.** If an Injury or Illness requires Emergency Services, the Member should notify HPN as soon as reasonably possible after the onset of the emergency.

HPN will review the use of the emergency room Retrospectively for appropriateness and to determine if the Covered Services received were Medically Necessary. Benefits for such services are payable if the services are determined to have been Emergency Services, as defined in this AOC.

1. **Non-Plan Providers.** If Emergency Services are provided by Non-Plan Providers, all Medically Necessary professional services and Inpatient or outpatient Hospital services will be covered subject to the other terms of this AOC.

   The Member should, at the earliest time reasonably possible, notify his PCP after the onset of an emergency.

2. **Payment.** Benefits for Emergency or Urgently Needed Services received from Non-Plan Providers are limited to the Eligible Medical Expenses for care required before the Member can safely receive services from his PCP.

3. **Follow-Up Care.** In order for benefits to be payable, the Member's PCP must provide follow-up care, unless authorized by HPN's Managed Care Program.

(b) **Outside the HPN Service Area.** Covered Services received while outside the HPN Service Area are limited to Emergency Services and Urgently Needed Services when care is required immediately and unexpectedly.

The Member should notify HPN as soon as reasonably possible after the onset of the emergency medical condition. Elective or specialized care will not be covered if the circumstances leading to the need for such care could have been foreseen before leaving HPN's Service Area.

1. **Payment.** Benefits are limited to the EME for such Covered Services. In addition, benefits for such services are not payable unless the Covered Services are determined to be Urgently Needed Services or Emergency Services as defined in this AOC.

2. **Follow-Up Care.** Continuing or follow-up treatment for Injury or Illness is limited to care required before the Member can safely return to HPN's Service Area.

   Once the Member is stabilized, benefits for continuing or follow-up treatment are provided only in HPN's Service Area, subject to all provisions of this AOC.

Telephone Advice Nurse: If you are feeling ill and are not sure about where you should go to obtain care or do not know whom to call, you may call the Telephone Advice Nurse for help. A nurse is available twenty-four (24) hours a day, seven (7) days a week at (702) 242-7330, or for the hearing-impaired through Relay Nevada's TDD/TYY at 1-800-326-6888. If you are traveling outside HPN's Service Area, you may call toll free for assistance at 1-800-288-2264.

5.8 Ambulance Services

Covered Services include Ambulance Services to the nearest appropriate Hospital. HPN will make direct payment to a Provider of Ambulance Services if the Provider does not receive payment from any other source. Ambulance Services will be reviewed on a Retrospective basis to determine Medical Necessity. The Member will be fully liable for the cost of Ambulance Services that are not Medically Necessary.

5.9 Physician Surgical Services – Inpatient and Outpatient

Covered Services include surgical services that are generally recognized and accepted procedures for diagnosing or treating an Illness or Injury.

5.10 Assistant Surgical Services

Covered Services include services performed by an assistant surgeon in connection with a covered surgical procedure but only to the extent surgical assistance is necessary due to the complexity of the procedure involved.

5.11 Gastric Restrictive Surgical Services

Covered Services include Prior Authorized Medically Necessary Gastric Restrictive Surgical Services for extreme obesity under the following circumstances:

- Have a body mass index (BMI) of greater than $40kg/m^2$; or
- Have a BMI greater than $35kg/m^2$ with significant co-morbidities; and
- Can provide documented evidence that dietary attempts at weight control are ineffective; and

- Must be at least 18 years old.

Documentation supporting the reasonableness and necessity of Gastric Restrictive Surgical Services is required, including compliant attendance at a medically supervised weight loss program (within the last twenty-four (24) months) for at least three (3) months with documented failure of weight loss. Significant clinical evidence that weight is affecting overall health and is a threat to life will also be required.

HPN requires that an initial psychological/psychiatric evaluation resulting in a recommendation for Gastric Restrictive Surgical Services is performed prior to review consideration by HPN's Managed Care Program. HPN may also require participation in a post-operative group therapy program.

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

5.12 Mastectomy Reconstructive Surgical Services

Covered Services for reconstructive procedures for Subscribers and their enrolled Dependents include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry including augmentation, mammoplasty, reduction mammoplasty, and mastopexy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.

5.13 Oral Physician Surgical Services

Although dental services are **not** Covered Services, the following Oral Physician Surgical Services are Covered Services:

- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Removal of teeth which is necessary in order to perform radiation therapy.
- Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Injury (not to include injuries caused by chewing) when the treatment starts within the first ten (10) days after the Injury and ends within sixty (60) days. Examples of Covered Services include:
    - Root canal therapy, post and build up.
    - Temporary crowns.
    - Temporary partial bridges.
    - Temporary and permanent fillings.
    - Pulpotomy.
    - Extractions of broken teeth.
    - Incision and drainage.
    - Tooth stabilization through splinting.

No benefits are provided for removable dental prosthetics, dentures (partial or complete) or subsequent restoration of teeth, including permanent crowns.

5.14 Organ and Tissue Transplant Surgical Services

All Covered Transplant Procedures are subject to the provisions of HPN's Managed Care Program and all other terms and provisions of the Plan, including the following:

1. HPN will determine if the Member satisfies HPN's Medically Necessary criteria before receiving benefits for transplant services.
2. HPN will provide a written Referral for care to a Transplant Facility.
3. If, after Referral, either HPN or the medical staff of the Transplant Facility determines that the Member does not satisfy the Medically Necessary criteria for the service involved, benefits will be limited to paying for Covered Services provided up to such determination.

Covered Transplant Procedures include the following services for human-to human organ or tissue transplants received during a Transplant Benefit Period on an Inpatient basis due to an Illness or Injury:

- Hospital room and board and medical supplies.
- Diagnosis, treatment, surgery and other Covered Services provided by a Physician.
- Organ and tissue retrieval which includes removing and preserving the donated part.
- Rental of wheel chairs, hospital-type beds and mechanical equipment required to treat respiratory impairment.
- Ambulance services.
- Medication, x-rays and other diagnostic services; laboratory tests; oxygen.
- Laboratory tests.
- Oxygen.
- Surgical dressings and supplies.
- Immunosuppressive drugs.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Transportation of the Member and a companion to and from the site of the transplant. If the Member is a minor, transportation of two (2) persons who travel with the minor is included. Reasonable and necessary lodging and meal costs incurred by such companions are included. Itemized receipts for these expenses are required. Daily lodging and meal costs will be paid up to the limit shown in the Attachment A Benefit Schedule. Benefits for all transportation, lodging and meal costs shall not exceed the maximum shown in the Attachment A Benefit Schedule for transportation, lodging and meals.

HPN makes no representation or warranty as to the medical competence or ability of any Transplant Facility or its respective staff or Physicians. HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inaction, whether negligent or otherwise, on the

part of any Transplant Facility or its respective staff or Physicians.

HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, in the event a transplant patient is injured or dies, by whatever cause, while enroute to a Transplant Facility.

If a Covered Transplant Procedure is not performed as scheduled due to a change in the Member's medical condition or death, benefits will be paid for Prior Authorized Eligible Medical Expenses incurred during the Transplant Benefit Period.

5.15 Home Healthcare Services

Covered Services include services given to a Member in his home by a licensed Home Healthcare Provider or an approved Hospital program for Home Healthcare. Such services are covered when a Member is homebound for medical reasons, physically not able to obtain Medically Necessary care on an outpatient basis, under the care of a Physician and such care is given in place of Inpatient Hospital or Skilled Nursing Facility care.

Covered Services and supplies provided by a Home Healthcare agency include:

- Professional services of a registered nurse, licensed practical nurse or a licensed vocational nurse on an intermittent basis.
- Physical therapy, speech therapy and occupational therapy by a licensed therapist.
- Medical and surgical supplies that are customarily furnished by the Home Healthcare agency or program for its patients.
- Prescribed drugs furnished and charged for by the Home Healthcare agency or program. Prescribed drugs under this provision do not include Specialty Prescription Drugs. Please refer to the optional HPN Prescription Drug Benefit Rider, if applicable to your Plan, for information on benefits available for Specialty covered drugs.
- One (1) medical social service consultation per course of treatment.
- One (1) nutrition consultation by a certified registered dietitian.
- Health aide services furnished to Member only when receiving nursing services or therapy.

5.16 Short-Term Rehabilitation Services

Short-Term Rehabilitation Covered Services therapy includes:

- Speech therapy.
- Occupational therapy.
- Physical therapy on an Inpatient or outpatient basis when ordered by the Member's PCP and authorized by HPN's Managed Care Program.

Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgment of the Member's PCP and HPN's Managed Care Program, are subject to significant improvement through Short-Term Rehabilitation therapy.

Covered Services do not include cardiac rehabilitation services provided on a non-monitored basis nor do they include treatment for mental retardation.

5.17 Genetic Disease Testing Services

Covered Services include Prior Authorized Medically Necessary Genetic Disease Testing, when:

- such testing is prescribed following the Member's history, physical examination and pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, and a definitive diagnosis remains uncertain and a genetic disease diagnosis is suspected, and;
- the Member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- the result of the test will directly impact the treatment being delivered to the Member.

5.18 Other Diagnostic and Therapeutic Services

Diagnostic and Therapeutic Covered Services when authorized by a Member's PCP and HPN's Managed Care Program include the following:

- anti-cancer drug therapy;
- complex allergy diagnostic services including RAST and allergoimmuno therapy;
- complex diagnostic imaging services including nuclear medicine, computerized axial tomography (CT scan), cardiac ultrasonography, magnetic resonance imaging (MRI), and arthrography;
- complex neurological diagnostic services including electroencephalograms (EEG), electromyogram (EMG) and evoked potential;
- complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill or stress testing, and impedance venous plethysmography;
- complex psychological diagnostic testing;
- complex pulmonary diagnostic services including pulmonary function testing and apnea monitoring;
- hemodialysis and peritoneal renal dialysis;
- other Medically Necessary intravenous therapeutic services as approved by HPN, including but not limited to, non-cancer related intravenous injection therapy;
- otologic evaluations only for the purpose of obtaining information necessary for evaluation of the need for or appropriate type of medical or surgical treatment for a hearing deficit or a related medical problem;
- Positron Emission Tomography (PET) Scans;
- therapeutic radiology services; and
- treatment of temporomandibular joint disorder.

Different Copayments may apply to these Covered Services. Please refer to your Attachment A Benefit Schedule.

5.19 Prosthetic and Orthotic Devices

Covered Services include the following when received in connection with an Illness or Injury and authorized by HPN's Managed Care Program:

- Cardiac pacemakers.
- Breast prostheses for post-mastectomy patients.
- Terminal devices (example: hand or hook) and artificial eyes.
- Braces which include only rigid and semi-rigid devices used for supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.
- Adjustment of an initial Prosthetic or Orthotic Device required by wear or by change in the patient's condition when ordered by a Plan Provider.

5.20 Durable Medical Equipment

All benefits for Durable Medical Equipment ("DME") includes administration, maintenance and operating costs of such equipment, if the equipment is Medically Necessary or Prior Authorized. DME includes, but is not limited to:

- Braces;
- Canes;
- Crutches;
- Intermittent positive pressure breathing machine;
- Hospital beds;
- Standard outpatient oxygen delivery systems;
- Traction equipment;
- Walkers;
- Wheelchairs; or
- Any other items that are determined to be Medically Necessary by HPN's Managed Care Program.

Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of significant change in the Member's physical condition.

HPN will not be responsible for the following:

- Non-Medically Necessary optional attachments and modifications to DME for the comfort or convenience of the Member;
- Accessories for portability or travel;
- A second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment;
- Home and car remodeling; and
- Replacement of lost or stolen equipment.

5.21 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:

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

5.22 Self-Management and Treatment of Diabetes

Coverage includes medication, equipment, supplies and appliances that are for the treatment of diabetes. Diabetes includes type I, type II and gestational diabetes. Covered Services include:

- supplies, training and education provided to a Member for the care and management of diabetes, after he is initially diagnosed with diabetes, to include counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
- supplies, training and education which is necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Member and which requires modification of his program of self-management of diabetes; and
- supplies, training and education which is necessary because of the development of new techniques and treatment for diabetes.

5.23 Special Food Products and Enteral Formulas

Covered Services include enteral formulas and special food product when prescribed by a Physician and authorized by HPN's Managed Care Program for treatment of an inherited metabolic disease.

- "Inherited Metabolic Disease" means a disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism or malabsorption of amino acid, organic acid, carbohydrate or fat.
- "Special Food Product" means a food product specially formulated to have less than one gram of protein per serving intended to be consumed under the direction of a Physician. The term does not include food that is naturally low in protein.

5.24 Mental Health Services and Severe Mental Illness Services

All benefits for Mental Health Services and Severe Mental Illness Services are subject to HPN's Managed Care Program through Behavioral Healthcare Options.

Mental Health Services. When authorized by Behavioral Healthcare Options, Covered Services include evaluation, crisis intervention or psychotherapy only.

- **Inpatient:** Covered Services for the diagnosis and treatment of a Mental Illness.
- **Outpatient:** Outpatient evaluation and treatment of Mental Illness including individual and group psychotherapy sessions.

Severe Mental Illness Services. When authorized by HPN, Covered Services include Inpatient and outpatient treatment for Severe Mental Illness as defined in this AOC.

For the purposes of determining benefits:

- Two (2) visits for partial or respite care, or a combination thereof, may be substituted for each day of hospitalization not used by the Member.
- No benefits are available for psychosocial rehabilitation or care received as a custodial Inpatient.

5.25 Substance Abuse Services

All benefits for Inpatient Substance Abuse Services are subject to HPN's Managed Care Program through Behavioral Healthcare Options.

- **Inpatient:** when there has been a history of multiple outpatient treatment failures or when outpatient treatment is not feasible, services for diagnosis and medical treatment for alcoholism and abuse of drugs.
- **Outpatient:** services for the diagnosis, medical treatment and rehabilitation, including individual, group, and family counseling, and outpatient detoxification services for recovery from the effects of alcoholism and abuse of drugs.
- **Detoxification:** 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.

NOTE: Member must contact Behavioral Healthcare Options at (702) 364-1484 or 1-800-873-2246 for Prior Authorization of all Mental Health, Severe Mental Illness or Substance Abuse treatment. If the Member is unable to contact Behavioral Healthcare Options due to an emergency admission, the Member must contact Behavioral Healthcare Options within twenty-four (24) hours of admission or at the earliest time reasonably possible, to authorize continued care.

All admissions for Emergency Services are reviewed Retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Member is admitted to a Mental Health, Severe Mental Illness or Substance Abuse facility for non-emergency treatment without Prior Authorization, Member will be responsible for the cost of services received.

5.26 Dental Anesthesia Services

Covered Services include general anesthesia when rendered in a Plan Hospital, Plan outpatient surgical facility, or other duly licensed Plan facility for an enrolled Dependent child, when such child, in the treating dentist's opinion and as Prior Authorized by the Plan, satisfies one or more of the following criteria:

- has a physical, mental or medically compromising condition;
- has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy;
- is extremely uncooperative, unmanageable or anxious; or
- has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Coverage for dental anesthesia pursuant to this section is limited to that provided by an anesthesia Plan Provider only during procedures performed by an educationally qualified Specialist in pediatric dentistry, or other dentist educationally qualified in a recognized dental specialty for which Hospital privileges are granted, or who is certified by virtue of completion of an accredited program of post-graduate Hospital training to be granted Hospital privileges.

5.27 Clinical Trial or Study

Covered Services include coverage for Prior Authorized medical treatment received as part of a clinical trial or study if the following provisions apply:

- The clinical trial or study is conducted in the state of Nevada and the medical treatment is provided:
  - In a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or other life-threatening disease or condition;
  - In a Phase II, Phase III or Phase IV clinical trial or study for the treatment of chronic fatigue syndrome;
  - For cardiovascular disease (cardiac/stroke) which is not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  - For surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
  - Other diseases or disorders which are not life-threatening not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- The clinical trial or study is approved by one of the following entities:
  1. An agency of the National Institutes of Health (NIH) as set forth in 42 U.S.C. § 281 (b);

2. The Centers for Disease Control and Prevention (CDC);
3. The Agency for Healthcare Research and Quality (AHRO);
4. Centers for Medicare and Medicaid Services (CMS);
5. A cooperative group;
6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet the both of following criteria:
   - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
   - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. HPN may, at any time, request documentation about the trial;
- The medical treatment is provided by a duly licensed Provider of healthcare and the facility and personnel have the experience and training to provide the medical treatment in a capable manner;
- There is no medical treatment available which is considered a more appropriate alternative than the medical treatment provided in the clinical trial or study;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; and
- The Member has signed a statement of consent before his participation in the clinical trial or study indicating that he has been informed of:
  1. The procedure to be undertaken;
  2. Alternative methods of treatment; and
  3. The risks associated with participation in the clinical trial or study.

Benefit coverage for medical treatment received during a clinical trial or study is limited to the following Covered Services:

- The initial consultation to determine whether the Member is eligible to participate in the clinical trial or study;
- Any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the Member, if the drug or device is not paid for by the manufacturer, distributor, or Provider:
- Services normally covered under this Plan that are required as a result of the medical treatment or related complications provided in the clinical trial or study when not provided by the sponsor of the clinical trial or study;
- Services required for the clinically appropriate monitoring of the Member during the clinical trial or study when not provided by the sponsor of the clinical trial or study.

Benefits for Covered Services in connection with a clinical trial or study are payable under this Plan to the same extent as any other Illness or Injury.

Services must be provided by an HPN Plan Provider. In the event an HPN Plan Provider does not offer a clinical trial with the same protocol as the one the Member's Plan Provider recommended, the Member may select a Non-Plan Provider performing a clinical trial with that protocol within the State of Nevada. If there is no Provider offering the clinical trial with the same protocol as the one the Member's Plan Provider recommended in Nevada, the Member may select a clinical trial outside the State of Nevada but within the United States of America. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

HPN will require a copy of the clinical trial or study certification approval, the Member's signed statement of consent, and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment.

5.28 Post-Cataract Surgical Services

Covered Services include Medically Necessary services provided for the initial prescription for corrective lenses (eyeglasses or contact lenses) and frames or intra-ocular lens implants for Post-Cataract Surgical Services.

Contact lenses will be provided if a Member's visual acuity cannot be corrected to 20/70 in the better eye except for the use of contact lenses.

5.29 Hearing Aids

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 Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Service for which benefits are available under the applicable medical/surgical Covered Services categories in the HPN AOC, only for Members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

5.30 Autism Spectrum Disorder

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders for Members under the age of 18 or, if enrolled in high school, until such Member reaches the age of 22. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst (including an Assistant Behavior Analyst and/or Autism Behavior Interventionist) or other provider that is supervised by the licensed physician, psychologist or behavior analyst and are subject to HPN's Managed Care Program. With the exception of the specific limitation on benefits for Applied Behavior Analysis ("ABA") as outlined in Attachment A Benefit Schedule, benefits for all Covered Services for the treatment of Autism Spectrum Disorders are payable to the same extent as other Covered Services and Covered Drugs under the Plan.

Covered Services for the treatment of Autism Spectrum Disorder do not include services provided by:

- an early intervention agency or school for services delivered through early intervention, or
- school services.

5.31 Pediatric Vision Services

Covered services are available to enrolled children up to age (19) when authorized by HPN's Managed Care Program.

Pediatric Vision coverage includes services for:

- Vision Examination;
- Lenses Frames;
- Contact Lenses;
- Low Vision Exam; and
- Optional Lenses and Treatments.

Please refer to the HPN Attachment A Benefit Schedule for the associated Member cost share and limitations.

5.32 Habilitative Services

Covered Services are provided for Habilitative Services provided on an outpatient basis for Members with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist and
- the initial or continued treatment must be proven and not experimental, investigational or unproven.

HPN will cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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.

Coverage for Habilitative Services does not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitative Services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Member reaches his maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

HPN may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Member's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Member to achieve demonstrable progress, HPN may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

SECTION 6. Exclusions

This section tells you what services or supplies are excluded from coverage under this Plan.

6.1 Services or supplies for which coverage is not specifically provided in this AOC, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.

6.2 Services not provided, directed, and/or Prior Authorized by a Member's PCP and HPN's Managed Care Program, except for Emergency Services and Urgently Needed Services.

6.3 Any charges for non-Emergency Services provided outside the United States.

6.4 Any services provided before the Effective Date or after the termination of this Plan.

6.5 Personal comfort, hygiene, or convenience items such as a Hospital television, telephone, or private room when not Medically Necessary. Services and supplies that are included in the basic hospital charges for room, board and nursing services. Housekeeping or meal services as part of Home Healthcare. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

6.6 Services for a private room in excess of the average semi-private room and board rate.

6.7 Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist.

Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitations shown in the Attachment A Benefit Schedule.

6.8 Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.

6.9 The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by HPN not to be Medically Necessary or not Prior Authorized by HPN's Managed Care Program:

- Advanced reproductive techniques such as embryo transplants, in vitro fertilization, GIFT and ZIFT procedures, assisted hatching, intracytoplasmic sperm injection, egg retrieval via laparoscope or needle aspiration, sperm preparation, specialized sperm retrieval techniques, sperm washing except prior to artificial insemination if required;
- Home pregnancy or ovulation tests;
- Sonohysterography;
- Monitoring of ovarian response to stimulants;
- CT or MRI of sella turcica unless elevated prolactin level;
- Evaluation for sterilization reversal;
- Laparoscopy;
- Ovarian wedge resection;
- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants;
- Surgical lysis of adhesions;
- Surgical tube reconstruction.

6.10 Services for the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and implantation of a penile prosthesis.

6.11 Reversal of surgically performed sterilization or subsequent resterilizations.

6.12 Elective abortions.

6.13 Any services or supplies rendered in connection with Member acting as or utilizing the services of a surrogate mother.

6.14 Third-party physical exams for employment, licensing, insurance, school, camp or adoption purposes. Immunizations related to foreign travel unless otherwise provided as a required preventive immunization identified by the USPSTF. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings are not covered.

6.15 Except as provided in the Covered Services Gastric Restrictive Surgical Services section, weight reduction procedures are excluded. Also excluded are any weight loss programs, whether or not recommended, provided or prescribed by a Physician or other medical Practitioner.

6.16 Except as provided in the Covered Services Organ and Tissue Transplant Surgical Services section, any human or animal transplant (organ, tissue, skin, blood, blood transfusions of bone marrow), whether human-to-human or involving a non-human device, artificial organs, or prostheses.

- Any and all services or supplies treatments, laboratory tests or x-rays received by the donor in connection with the transplant (including donor search, donor transportation, testing, registry and retrieval/harvesting costs) and costs related to cadaver or animal retrieval or maintenance of a donor for such retrieval.
- Any and all Hospital, Physician, laboratory or x-ray services in any way related to any excluded transplant service, procedure or treatment.

6.17 Treatment of:

- Marital or family problems;
- Occupational, religious, or other social maladjustments;
- Codependency;
- Impulse control disorders;
- Organic disorders;
- Learning disabilities or mental retardation or any Severe Mental Illness as defined in the AOC and otherwise covered under the Severe Mental Illness Covered Services section.

For purposes of this Exclusion:

- Counseling and other forms of cognitive and behavioral therapy is excluded in connection with the treatment of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD). This section is not meant to exclude an evaluation for a diagnosis of ADD or ADHD, or to exclude any corresponding outpatient prescription drugs (if otherwise available under the outpatient Prescription Drug Benefit Rider if applicable to your Plan) when prescribed by a treating Plan Provider, nor is this meant to exclude an evaluation for the diagnosis of any other co-morbid issues.

6.18 Institutional care which is determined by HPN's Managed Care Program 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.

6.19 Except as otherwise provided in the Attachment A Benefit Schedule, vision exams to determine refractive errors of vision and eyeglasses or contact lenses other than as specifically covered in this Plan. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.

6.20 Except as otherwise provided in the Attachment A Benefit Schedule, any prescription corrective lenses (eyeglasses or contact lenses) or frames following Post-Cataract Surgical Service which include, but are not limited to the following:

- Coated lenses;
- Cosmetic contact lenses;
- Costs for lenses and frames in excess of the Plan allowance;
- No-line bifocal or trifocal lenses;
- Oversize lenses;
- Plastic multi-focal lenses;
- Tinted or photochromic lenses;
- Two (2) pairs of lenses and frames in lieu of bifocal lenses and frames; or
- All prescription sunglasses.

6.21 Hearing exams to determine the need for or the appropriate type of hearing aid or similar devices, other than as specifically covered in this Plan. Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.

6.22 Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile or gerovital.

6.23 Pain management invasive procedures as defined by HPN's protocols for chronic, intractable pain unless Prior Authorized by HPN and provided by a Plan Provider who is a pain management Specialist. Any Prior Authorized pain management procedures will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in Attachment A Benefit Schedule.

6.24 Acupuncture or hypnosis.

6.25 Treatment of an Illness or Injury caused by or arising out of a riot, declared or undeclared war or act of war, insurrection, rebellion, armed invasion or aggression.

6.26 Treatment of an occupational Illness or Injury which is any Illness or Injury arising out of or in the course of employment for pay or profit.

6.27 Travel and accommodations, whether or not recommended or prescribed by a Provider, other than as specifically covered in this Plan.

6.28 Outpatient Prescription Drugs, nutritional supplements, vitamins, herbal medicines, appetite suppressants, Specialty drugs, and other over-the-counter drugs, except as specifically covered in the outpatient Prescription Drug Benefit Rider, if applicable to your Plan. This includes drugs and supplies for a patient's use after discharge from a Hospital. Drugs and medicines approved by the FDA for experimental, investigational or unproven use or any drug that has been approved by the FDA for less than one (1) year unless Prior Authorized by HPN.

6.29 Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.

6.30 Any equipment or supplies that condition the air. Arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace. Heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment.

6.31 Any service or supply in connection with routine foot care, including the removal of warts, corns, or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches and chronic foot strain in the absence of severe systemic disease.

6.32 Special formulas, food supplements other than as specifically covered in this Plan or special diets on an outpatient basis (except for the treatment of inherited metabolic disease).

6.33 Services, supplies or accommodations provided without cost to the Member or for which the Member is not legally required to pay.

6.34 Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, residential treatment, vocational rehabilitation and wilderness programs.

6.35 Experimental, investigational, or unproven treatment or devices as determined by HPN.

6.36 Sports medicine treatment plans intended to primarily improve athletic ability.

6.37 Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.

6.38 Any services given by a Provider to himself or to members of his family.

6.39 Ambulance services when a Member could be safely transported by other means. Air Ambulance services when a Member could be safely transported by ground Ambulance or other means.

6.40 Late discharge billing and charges resulting from a canceled appointment or procedure.

6.41 Autologous blood donations.

6.42 Covered Services received in connection with a clinical trial or study which includes the following:

- Healthcare services that are specifically excluded from coverage under this Plan regardless of whether such services are provided under the clinical trial or study;
- Healthcare services that are customarily provided by the sponsors of the clinical trial or study free of charge to the Member in the clinical trial or study;
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing and other expenses that a Member may incur;
- Any expenses incurred by a person who accompanies the Member during the clinical trial or study;
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the Member; and
- Any cost for the management of research relating to the clinical trial or study.

6.43 If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare.

6.44 Services provided by non-participating vision care providers.

6.45 Charges for services by a vision Plan Provider to his or her Dependents.

6.46 Visual therapy.

6.47 Replacement of lost or stolen eyewear.

6.48 Two pairs of eyeglasses in lieu of bifocals.

6.49 Services or materials provided under Workers' Compensation or Employer's Liability laws.

6.50 Services provided or paid for by governmental agency or under any governmental program or law, except charges which the member is legally obligated to pay.

6.51 Services performed for cosmetic purposes or to correct congenital malformations.

6.52 Services and materials resulting from failure to comply with professionally prescribed treatment.

6.53 Telephone consultations.

6.54 Bone anchored hearing aids are excluded except when either of the following applies:

- For Member's with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- For Member's with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Also excluded is more than one bone anchored hearing aid per Member who meets the above coverage criteria during the entire period of time the Member is enrolled under the Plan, as well as repairs and/or replacements for a bone anchored hearing aid for Member's who meet the above coverage criteria, other than for malfunctions.

SECTION 7. Limitations

This section tells you when HPN's duty to provide or arrange for services is limited.

7.1 Liability

HPN will not be liable for any delay or failure to provide or arrange for Covered Services if the delay or failure is caused by the following:

a) Civil insurrection.
b) Epidemic.
c) Natural disaster.
d) Riot.
e) War.
f) Or any other emergency beyond HPN's control.

In the event of one of these types of emergencies, HPN and its Plan Providers will provide the Covered Services shown in this AOC to the extent practical according to their best judgment.

7.2 Calendar Year and Lifetime Maximum Benefit Limitations

Please see the Attachment A Benefit Schedule for Calendar Year and/or lifetime maximums applicable to certain benefits.

7.3 Reimbursement

Reimbursement for Covered Services approved by HPN and provided by a Non-Plan Provider outside HPN's Service Area shall be limited to the average payment which HPN makes to Plan Providers in HPN's Service Area.

SECTION 8. Coordination of Benefits (COB)

This section tells you how other health insurance you may have affects your coverage under this Plan.

8.1 The Purpose of COB

Coordination of Benefits (COB) is intended to help contain the cost of providing healthcare coverage. When an individual person has dual coverage through HPN and another healthcare

plan, the COB guidelines outlined in this Section apply. The COB guidelines explain how, in a dual healthcare coverage situation, benefits are coordinated or shared by each plan.

8.2 Benefits Subject to COB

All of the healthcare benefits provided under this AOC are subject to this Section. The Member agrees to permit HPN to coordinate its obligations under this AOC with payments under any other Health Benefit Plan that covers the Member.

8.3 Definitions

Some words in this Section have a special meaning to meet the needs of this Section. These words and their meaning when used are:

(a) "**Plan**" will mean an entity providing healthcare benefits or services by any of the following methods:

1. Insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis, including the following:

   a. Hospital indemnity benefits with regard to the amount in excess of $30 per day.

   b. Hospital reimbursement type plans which permit the insured person to elect indemnity benefits at the time of claim.

2. Service plan contracts, group practice, individual practice and other prepayment coverage.

3. Any coverage for students that is sponsored by, or provided through, school or other educational institutions, other than accident coverage for grammar school or high school students that the parent pays the entire premium.

4. Any coverage under labor management trusteed plans, union welfare plans, employer organization plans, employee benefit plans, or employee benefit organization plans.

5. Coverage under a governmental program, including Medicare and workers' compensation plans.

The term "Plan" will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(b) "**Allowable Expense**" means the Eligible Medical Expense for Medically Necessary Covered Services. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be an Allowable Expense and a benefit paid.

(c) "**Claim Determination Period**" means the Calendar Year.

(d) "**Primary Plan**" means a Plan that, in accordance with the rules regarding the order of benefits determination, provides benefits or benefit payments without considering any other Plan.

(e) "**Secondary Plan**" means a Plan that in accordance with the rules regarding the order of benefit determination, may reduce its benefits or benefit payments and/or recover from the Primary Plan benefit payments.

8.4 When COB Applies

COB applies when a Member covered under this Plan is also entitled to receive payment for or provision of some or all of the same Covered Services from another Plan.

8.5 Determination Rules

The rules establishing the order of benefit determination are:

(a) **Non-Dependent or Dependent**. A Plan that covers the person as a Subscriber is primary to a Plan that covers the person as a Dependent.

(b) **Dependent Child of Parents Not Separated or Divorced**. Except as stated in 8.5(c) below, when this Plan and another Plan cover the same child as a Dependent of different parents:

1. The Plan of the parent whose birthday falls earlier in the Calendar Year is primary to the Plan of the parent whose birthday falls later in the year.

2. If both parents have the same birthday, the Plan that has covered a parent for a longer period of time is primary.

3. If the other Plan does not have the rule described in (1) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(c) **Dependent Child of Separated or Divorced Parents.** If two (2) or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. If there is a court decree that would establish financial responsibility for the medical, dental or other healthcare expenses with respect to the child, the benefits of a Plan that covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan that covers the child as a Dependent child;
2. Second, the Plan of the parent with custody of the child;
3. Third, the Plan of the spouse (stepparent) of the parent with custody of the child;
4. Finally, the Plan of the parent not having custody of the child.

(d) **Active/Inactive Subscriber**. A Plan that covers a person as a Subscriber who is neither laid-off nor retired (or that Subscriber's Dependents) is primary to a Plan that covers that person as a laid-off or retired Subscriber (or that Subscriber's Dependents). If the other Plan does not have this rule, and if as a result, the Plans do not agree on the order of benefits, this rule (d) is ignored.

(e) **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the Plan that covered the person for a longer period of time is primary to the Plan which covered that person for the shorter time period.

Two consecutive Plans shall be treated as one Plan if:
1. That person was eligible under the second Plan within 24 hours after the termination of the first Plan; and
2. There was a change in the amount or scope of a Plan's benefits or there was a change in the entity paying, providing or administering Plan benefits; or
3. There was a change from one type of Plan to another (e.g., single employer to multiple employer Plan).

(f) **If No COB Provision**. If another Plan does not contain a provision coordinating its benefits with those of this Plan, the benefits of such other Plan will be considered primary.

8.6 How COB Works

Plans use COB to decide which healthcare coverage programs should be the Primary Plan for the Covered Service. If the Primary Plan payment is less than the charge for the Covered Service, then the Secondary Plan will apply its Allowable Expense to the unpaid balance. Benefits payable under another Plan include the benefits that would have been payable if the Member had filed a claim for them.

8.7 Right to Receive and Release Information

In order to decide if this COB Section (or any other Plan's COB Section) applies to a claim, HPN (without the consent of or notice to any person) has the right to the following:
(a) Release to any person, insurance company or organization, the necessary claim information.
(b) Receive from any person, insurance company or organization, the necessary claim information.
(c) Require any person claiming benefits under this Plan to give HPN any information needed by HPN to coordinate those benefits.

8.8 Facility of Payment

If another Plan makes a payment that should have been made by HPN, then HPN has the right to pay the other Plan any amount necessary to satisfy HPN's obligation. Any amount paid shall be deemed to be benefits paid under this Plan, and to the extent of such payments, HPN shall be fully discharged from liability under this Plan.

8.9 Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy HPN's obligation under this section, HPN has the right to recover the excess amount from one or more of the following:
(a) Any persons to or for whom such payments were made.
(b) Any insurance companies or service plans.
(c) Any other organizations.

8.10 Failure to Cooperate

If a Member fails to cooperate with HPN's administration of this section, the Member may be responsible for the expenses for the services rendered and if legal action is taken, a court could make the Member responsible for any legal expense incurred by HPN to enforce its rights under this section.

Member cooperation includes the completion of the necessary paperwork that would enable HPN to collect payment from the Primary Plan for services. Any benefits paid to the Member in excess of actual expenses must be refunded to HPN.

SECTION 9. Premium Payments, Grace Period and Changes in Premium Rates

This section tells you when premium payments are due, what happens when payments are not received and when premium rates can change.

9.1 Monthly Payments

The first day of any calendar month is the premium due date. On or before the premium due date, the Subscriber shall remit to HPN, on behalf of the Subscriber and his covered Family Members the premium amount specified by HPN.

9.2 Grace Period

Only Members for whom premium payment is actually received by HPN shall be entitled to Covered Services hereunder and then only for the period for which such payment is received. HPN shall not be liable for any healthcare services incurred by any Member beyond the period for which the premium payments shall have been paid, and HPN shall be entitled to receive reimbursement from the Subscriber for any claims paid by HPN for services provided after the date of termination.

9.3 Changes in Premium Payments

HPN reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber thirty (30) day notice prior to the Annual Open Enrollment as established by Federal guidelines.

SECTION 10. General Provisions

10.1 Relationship of Parties

The relationship between HPN and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of HPN; nor is HPN, or any employee of HPN, an employee or agent of a Plan Provider. HPN is not liable for any claim or demand on account of damages as a result of, or in any manner connected with, any Injury suffered

by a Member while receiving care from any Plan Provider or in any Plan Provider's facility. HPN is not bound by statements or promises made by its Plan Providers.

10.2 Entire Agreement

This AOC, including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Member's Enrollment Application Form, health statements, Member Identification Card, and all other applications received by HPN constitutes the entire agreement between the Member and HPN and as of its Effective Date, replaces all other agreements between the parties. For the duration of time a Member's coverage is continuously effective under HPN, regardless of the occurrence of any specific Plan or product changes during such time, all benefits paid by HPN under any and all such Plans on behalf of such Member shall accumulate towards any applicable lifetime or other maximum benefit amounts as stated in the Member's most current Plan Attachment A Benefit Schedule to the AOC.

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

In the event HPN decides to discontinue offering and renewing health benefit plans delivered or issued for delivery in this state, HPN will provide notice of its intention to all persons covered by the discontinued insurance at least 180 days before the nonrenewal of any health benefit plan by the HPN.

10.3 Contestability

Any and all statements made to HPN by any Subscriber or Dependent, will, in the absence of fraud, be considered representations and not warranties. Also, no statement, unless it is contained in a written application for coverage, shall be used in defense to a claim under this agreement.

10.4 Authority to Change the Form or Content of AOC

No agent or employee of HPN is authorized to change the agreement or waive any of its provisions. Such changes can be made only through an amendment authorized and signed by an officer of HPN.

10.5 Identification Card

Cards issued by HPN to Members are for identification only. Possession of the HPN identification card does not give right to services or other benefits under this Plan.
To be entitled to such services or benefits, the holder of the card must in fact be a Member and all applicable premiums must actually have been paid. Any person not entitled to receive services or other benefits will be liable for the actual cost of such services or benefits.

10.6 Notice

Any notice under this Plan may be given by United States mail, first class, postage paid, addressed as follows:

Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, Nevada 89114 5645

Notice to a Member will be sent to the Member's last known address.

10.7 Interpretation of AOC

The laws of the jurisdiction of issue shall be applied to interpretation of this AOC. Where applicable, the interpretation of this AOC shall be guided by the direct-service nature of HPN's operation as opposed to a fee-for-service indemnity basis.

10.8 Assignment

This Plan is not assignable without the written consent of HPN. The coverage and any benefits under this Plan are not assignable by any Member without the written consent of HPN

10.9 Modifications

This Plan is subject to amendment, modification and termination with sixty (60) days written notice to the Member. This Plan will automatically be modified to conform with any State or Federal law requirements. HPN reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber thirty (30) day notice prior to the Annual Open Enrollment as established by Federal guidelines.

By electing medical coverage with HPN or accepting benefits under this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all of the terms and provisions.

10.10 Clerical Error

Clerical error in keeping any record pertaining to the coverage will not invalidate coverage in force or continue coverage terminated.

10.11 Policies and Procedures

HPN may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan with which Members shall comply. These policies and procedures are maintained by HPN at its offices. Such policies and procedures may have bearing on whether a medical service and/or supply is covered.

10.12 Overpayments

HPN has the right to collect payments for healthcare services made in error. Hospitals, Physicians, other Providers, and/or

the Subscriber have the responsibility to return any overpayments or incorrect payments to HPN. HPN has the right to offset any overpayment against any future payments.

10.13 Cost Containment Features

This Plan contains at least the following cost containment provisions:
(a) Preventive healthcare benefits.
(b) HPN's Managed Care Program.
(c) Benefit limitations on certain services.
(d) Member Copayments.

10.14 Release of Records.

Each Member authorizes the Physician, Hospital, Skilled Nursing Facility or any other Provider of healthcare to permit the examination and copying of the Member's medical records, as requested by HPN.

Information from medical records and information received from Physicians or Hospitals incident to the Physician/Patient relationship or Hospital/Patient relationship shall be kept confidential and except for use in connection with government requirements established by law or the administration of this Plan, records may not be disclosed to any unrelated third party without the Member's consent.

10.15 Reimbursement for Claims

Non-Plan Providers may require immediate payment for their services and supplies. When seeking reimbursement from HPN for expenses incurred in connection with services received from Non-Plan Providers, the Member must complete a Non-Plan Provider Claim Form and submit it to the HPN Claims Department with copies of all of the medical records, bills and/or receipts from the Provider. Non-Plan Provider Claim Forms can be obtained by contacting the Member Services Department at 1-877-752-8026 (English) or 1-877-512-9339 (Español).

If the Member receives a bill for Covered Services from a Non-Plan Provider, the Member may request that HPN pay the Provider directly by sending the bill, with copies of all medical records and a completed Non-Plan Provider Claim Form to the HPN Claims Department.

HPN shall approve or deny a claim within thirty (30) days after receipt of the claim. If the claim is approved, the claim shall be paid within thirty (30) days from the date it was approved. If the approved claim is not paid within that thirty (30) day period, HPN shall pay interest on the claim at the rate set forth by applicable Nevada law. The interest will be calculated from thirty (30) days after the date on which the claim is approved until the date upon which the claim is paid.

HPN may request additional information to determine whether to approve or deny the claim. HPN shall notify the Provider of its request for additional information within twenty (20) days after receipt of the claim. HPN will notify the Provider of the healthcare services of all the specific reasons for the delay in approving or denying the claim. HPN shall approve or deny the claim within thirty (30) days after receiving the additional information. If the claim is approved, HPN shall pay the claim within thirty (30) days after it receives the additional information. If the approved claim is not paid within that time period, HPN shall pay interest on the claim in the manner set forth above.

If HPN denies the claim, notice to the Member will include the reasons for the rejection and the Member's right to file a written complaint as set forth in the Appeals Procedures section herein.

10.16 Timely Filing Requirements

All claims must be submitted to HPN within sixty (60) days from the date expenses were incurred, unless it shall be shown not to have been reasonably possible to give notice within the time limit, and that notice was furnished as soon as was reasonably possible. If Member authorizes payment directly to the Provider, a check will be mailed to that Provider. A check will be mailed to the Member directly if payment directly to the Provider is not authorized. Member will receive an explanation of how the payment was determined.

No payments shall be made under this Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by HPN within twelve (12) months after the date Covered Services were provided. In no event will HPN pay more than HPN's Eligible Medical Expense for such services.

10.17 Gender References

Whenever a masculine pronoun is used in this AOC, it also includes the feminine pronoun.

10.18 Legal Proceedings

No action of law or equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of claim has been filed according to the requirements of the Plan. No such action shall be brought at any time unless brought within the time limit allowed by the laws of the jurisdiction of issue.

If the laws of the jurisdiction of issue do not designate the maximum length of time in which such action may be brought, no action may be brought after the expiration of three (3) years from the time proof of loss is required by the Plan.

10.19 Availability of Providers

HPN does not guarantee the continued availability of any Plan Provider.

10.20 Physician Incentive Plan Disclosure

You are entitled to ask if HPN has special financial arrangements with their contracted Physicians that may affect Referral services, such as lab tests and hospitalizations that you might need. To receive information regarding contracted Physician payment arrangements, please call the Member Services Department at 1-877-752-8026 (English) or 1-877-

512-9339 (Español). This information will be sent to you within thirty (30) days of the date that you make your request.

HPN will provide information on the financial arrangements that they have with their contracted Physicians to any requesting Member. The following information is available upon request, to current, previous and potential Plan Members:

1. Whether HPN's Managed Care Organization contracts or subcontracts include Physician incentive plans that affect the use of Referral services.
2. Information on the type of arrangements used.
3. Whether special insurance called stop-loss protection is required for Physicians or Physician's groups.

10.21 Authorized Representative

A Member may elect to designate an "Authorized Representative" to act on their behalf to pursue a Claim for Benefits or the appeal of an Adverse Benefit Determination. The term Member also includes the Member's Authorized Representative, where applicable and appropriate. To designate an Authorized Representative, a written notice, signed and dated by the Member, is required. The notice must include the full name of the Authorized Representative and must indicate specifically for which Claim for Benefits or appeal the authorization is valid. The notice should be sent to:

Health Plan of Nevada, Inc.
Attn: Customer Response and Resolution Dept.
P.O. Box 15645
Las Vegas, NV 89114-5645

Any correspondence from HPN regarding the specified Claim for Benefits or appeal will be provided to both the Member and his Authorized Representative.

In case of an Urgent Care Claim, a healthcare professional with knowledge of the Member's medical condition shall be permitted to act as an Authorized Representative of the Member without designation by the Member.

10.22 Failure to Obtain Prior Authorization

All requests for Prior Authorization must be initiated by the Member's Physician. If a Physician or Member fails to follow the Plan's procedures for filing a request for Prior Authorization (Pre-Service Claim), the Member shall be notified of the failure and the proper procedures to be followed in order to obtain Prior Authorization provided the Member's request for Prior Authorization is received by an employee or department of the Plan customarily responsible for handling benefit matters and the original request specifically named the Member, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The Member notification of correct Prior Authorization procedures from the Plan shall be provided as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of an Urgent Care Claim) following the Plan's receipt of the Member's original request. Notification by HPN may be oral unless specifically requested in writing by the Member.

10.23 Timing of Notification of Benefit Determination

Concurrent Care Decision: If HPN has approved an ongoing course of treatment to be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, HPN will notify the Member at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination before the benefit is reduced or terminated. Subject to the paragraph below, such request may be treated as a new Claim for Benefits and decided within the timeframes applicable to either a Pre-Service Claim or a Post-Service Claim as appropriate. Provided, however, any appeal of such a determination must be made within a reasonable time and may not be afforded the full 180 day period as described in the Appeals Procedures section herein.

Any request by a Member to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim shall be decided as soon as possible. HPN shall notify the Member within twenty-four (24) hours after receipt of the Claim for Benefits by the Plan, provided that the request is received at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments. If the request is not made at least twenty-four (24) hours prior to the expiration of the authorized period of time or number of treatments, the request will be treated as an Urgent Care Claim.

10.24 Notification of an Adverse Benefit Determination

If you receive an Adverse Benefit Determination, you will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claim for Benefits to be approved, modified or reversed, and an explanation of why such material or information is necessary;
- A description of the review procedures and the time limits applicable to such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an appeal of an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or experimental, investigational or unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

SECTION 11. Appeals Procedures

The HPN Appeals Procedures are available to you in the event you are dissatisfied with some aspect of the Plan administration or you wish to appeal an Adverse Benefit Determination. This procedure does not apply to any problem of misunderstanding or misinformation that can be promptly resolved by the Plan supplying the Member with the appropriate information.

If a Member's Plan is governed by ERISA, the Member must exhaust the mandatory level of mandatory appeal before bringing a claim in court for a Claim of Benefits.

Concerns about medical services are best handled at the medical service site level before being brought to HPN. If a Member contacts HPN regarding an issue related to the medical service site and has not attempted to work with the site staff, the Member may be directed to that site to try to solve the problem there, if the issue is not a Claim for Benefits.

Please see the Glossary Terms Section herein for a description of the terms used in this section.

The following Appeals Procedures will be followed if the medical service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits. All Appeals will be adjudicated in a manner designed to ensure independence and impartiality on the part of the persons making the decision.

Formal Appeal: An appeal of an Adverse Benefit Determination filed either orally or in writing which HPN's Customer Response and Resolution Department investigates. If a Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The Formal Appeal is **mandatory** if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

Member Services Representative: An employee of HPN that is assigned to assist the Member or the Member's Authorized Representative in appealing an Adverse Benefit Determination.

11.1 Formal Appeal

A Formal Appeal must be submitted orally or in writing to HPN's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

A Formal Appeal shall contain at least the following information:
- The Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;
- The Member's HPN membership number ; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

Additionally, the Member may submit any supporting medical records, Physician's letters, or other information that explains why HPN should approve the Claim for Benefits. The Member can request the assistance of a Member Services Representative at any time during this process.

The Formal Appeals should be sent or faxed to the following:

Health Plan of Nevada, Inc.
Attn: Customer Response and Resolution Department
PO Box 14865
Las Vegas, NV 89114
Fax: 1-702-266-8813

HPN will investigate the appeal. When the investigation is complete, the Member will be informed in writing of the resolution within thirty (30) days of receipt of the request for the Formal Appeal. This period may be extended one (1) time by HPN for up to fifteen (15) days, provided that the extension is necessary due to matters beyond the control of HPN and HPN notifies the Member prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which HPN expects to render a decision. If the extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Member shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

If the Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:
- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or experimental, investigational or unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge as well as information regarding the Member's right to request an External Review by the State of Nevada's Office for Consumer Health Assistance (OCHA).

Limited extensions may be required if additional information is required in order for HPN to reach a resolution.

11.2 Expedited Appeal

The Member can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that involves an Urgent Care Claim if the

Member or his Physician believe that the health of the Member could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim) or for Pre-Service Claims that are not Urgent Care Claims. Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to HPN. If the initial notification was oral, HPN shall provide a written or electronic explanation to the Member within three (3) days of the oral notification.

If insufficient information is received, HPN shall notify the Member as soon as possible, but no later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. The Member will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. HPN shall notify the Member of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

- HPN's receipt of the specified information, or
- The end of the period afforded the Member to provide the specified information.

If the Member's Physician requests an Expedited Appeal, or supports a Member's request for an Expedited Appeal, and indicates that waiting for a routine appeal could seriously harm the health of the Member or subject the Member to unmanageable severe pain that cannot be adequately managed without care or treatment that is the subject of the Claim for Benefits, HPN will automatically grant an Expedited Appeal.

If a request for an Expedited Appeal is submitted without support of the Member's Physician, HPN shall decide whether the Member's health requires an Expedited Appeal. If an Expedited Appeal is not granted, HPN will provide a decision within thirty (30) days, subject to the routine appeals process for Pre-Service Claims.

11.3 Arbitration of Disputes of an Independent Medical Review

If the Member is dissatisfied with the findings of an Independent Medical Review, the Member shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association. This review is in place of HPN's Appeals Procedures.

The arbiter will be selected by mutual agreement of HPN and the Member. The cost and expense of the arbitration shall be paid by HPN. The decision of the arbiter shall be binding upon the Member and HPN.

11.4 External Review

HPN offers to the Member or the Member's Authorized Representative the right to an External Review of an adverse determination. For the purposes of this section, a Member's Authorized Representative is a person to whom a Member has given express written consent to represent the Member in an External Review of an adverse determination; or a person authorized by law to provide substituted consent for a Member; or a family member of a Member or the Member's treating provider only when the Member is unable to provide consent.

Adverse determinations eligible for External Review set forth in this section are only those relating to Medical Necessity, appropriateness of service, healthcare service, healthcare setting, or level of care or effectiveness of a healthcare service. HPN will provide the Member notice of such an adverse determination which will include the following statement:

> HPN has denied your request for the provision or payment of a requested healthcare service or course of treatment. You may have the right to have our decision reviewed by 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 to the Office for Consumer Health Assistance.

Additionally, as per applicable law and regulations, the notice will provide the Member the information outlined in Section 11.2 as well as the following:

- The telephone number for the Office for Consumer Health Assistance for the state of jurisdiction of the health carrier and the state in which the Member resides.
- The right to receive correspondence in a culturally and linguistically appropriate manner.

The notice to the Member or the Member's Authorized Representative will also include a HIPAA compliant authorization form by which the Member or the Member's Authorized Representative can authorize HPN and the Member's Physician to disclose protected health information ("PHI"), including medical records, that are pertinent to the External Review, and any other forms as required by Nevada law or regulation.

The Member or the Member's Authorized Representative may submit a request directly to OCHA for an External Review of an adverse determination by an Independent Review Organization ("IRO") within four (4) months of the Member or the Member's Authorized Representative receiving notice of such determination. The IRO must be certified by the Nevada Division of Insurance. Requests for an External Review must be made in writing and submitted to OCHA at the address below and should include the signed HIPAA authorization form, authorizing the release of your medical records. The entire External Review process and any associated medical records are confidential.

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

The determination of an IRO concerning an External Review in favor of the Member of an adverse determination is final, conclusive and binding. Upon receipt of the notice of a

decision by the IRO reversing an adverse determination, HPN shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination. The cost of conducting an External Review of an adverse determination will be paid by HPN.

11.4.a Standard External Review

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

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

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

- Any medical records of the Member relating to the adverse determination;
- A copy of the provisions of this Plan upon which the adverse determination was based;
- Any documents used and the reason(s) given by HPN's Managed Care Program for the adverse determination; and
- 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 HPN, 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 HPN 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:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

11.4.b Expedited External Review

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:

- An inpatient admission;
- availability of inpatient care;
- continued stay or health care service for Emergency Services while still admitted to an inpatient facility; or
- 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 with 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. HPN 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 HPN 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:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

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

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

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

11.5.a Standard External Review

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.

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

Within one (1) business day of making such a determination, HPN will notify in writing, the Member or the Member's Authorized Representative and OCHA, accordingly. If HPN determines that the case is incomplete and/or ineligible, HPN 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 HPN'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.

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

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 IRO shall submit a copy of its determination, including the basis thereof, to the:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

11.5.b Expedited External Review

The Member or the Member's Authorized Representative may request in writing, an internal Expedited appeal by HPN and an Expedited External Review from OCHA simultaneously if the adverse determination of the requested or recommended service or treatment is determined by HPN to be experimental, investigational or unproven, and, if the treating provider certifies, in writing, that such service or treatment would be less effective if not promptly initiated.

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 HPN accordingly.

HPN 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 HPN determines the request to be ineligible, the Member will be notified that the request may be appealed to OCHA.

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

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 HPN by the IRO within one (1) business day.

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:

- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

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

11.6 Office for Consumer Health Assistance

- (702) 486-3587 in Las Vegas area
- 1-888-333-1597 outside of Las Vegas area (toll-free)

SECTION 12. Glossary

12.1 **"Advance Premium Tax Credit"** means a Federal subsidy that will pay a portion of an individual's or family's health insurance premium.

12.2 **"Adverse Benefit Determination"** means a rescission of coverage; a decision by HPN to deny, reduce, terminate, fail to provide, or make payment for a benefit, including a denial, reduction termination, or failure to provide, or make a payment for a benefit that is based on: an individual's eligibility; a determination that a benefit is not a Covered Service; other limitation on an otherwise Covered Service; or a determination that a benefit is experimental, investigational, unproven or not Medically Necessary or appropriate.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity,

appropriateness, health care setting, level of care, or effectiveness of a Covered Service An Adverse Benefit Determination is final if the Member has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

12.3 **"Agreement of Coverage" or "AOC"** means this document, including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Member's Enrollment Form, health statements, Member Identification Card, and all other applications received by HPN.

12.4 **"Ambulance"** means a ground or air vehicle licensed to provide Ambulance services.

12.5 **"Ambulatory Surgical Facility"** means a facility that:

- Is licensed by the state where it is located.
- Is equipped and operated mainly to provide for surgeries or obstetrical deliveries.
- Allows patients to leave the facility the same day the surgery or delivery occurs.

12.6 **"Application Review Period"** means the period of time that must pass before coverage for an individual or Eligible Family Member can become effective. The Application Review Period begins on the date the individual submits a substantially complete application for coverage and ends on the following:

- the date coverage begins if the application results in coverage; or
- the date on which the application is denied by HPN if the application does not result in coverage; or
- the date on which the offer for coverage lapses if the application does not result in coverage.

12.7 **"Applied Behavior Analysis"** or **"ABA"** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

12.8 **"Authorized Representative"** means a person designated by the Member to act on his behalf in pursuing a Claim for Benefits, to file an appeal of an adverse determination or in obtaining an External Review of a final Adverse Benefit Determination. The designation must be in writing unless the claim or appeal involves an Urgent Care Claim and a healthcare professional with knowledge of the Member's medical condition is seeking to act on the Member's behalf as his Authorized Representative.

12.9 **"Benefit Schedule"** means the brief summary of benefits, limitations and Copayments given to the Subscriber by HPN. It is Attachment A to this AOC.

12.10 **"Autism Behavior Interventionist"** means a person who is certified as an Autism Behavior Interventionist by the Board of Psychological Examiners and who provides Behavior Therapy under the supervision of:

1. A licensed psychologist;
2. A Licensed Behavior Analyst; or
3. A Licensed Assistant Behavior Analyst.

12.11 **"Autism Spectrum Disorders"** means a neurobiological medical condition including, but not limited to, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.

12.12 **"Blended Lenses"** means bifocals which do not have a visible dividing line.

12.13 **"Calendar Year"** means January 1 through December 31 of the same year.

12.14 **"Calendar Year Out of Pocket Maximum"** means the maximum amount of Out of Pocket expenses a Member is required to pay for Covered Services in a Calendar Year, as outlined in the Attachment A, Schedule of Benefits. Once the Calendar Year Out of Pocket Maximum is met, no further cost share is required for the remainder of the Calendar Year.

The Out of Pocket Maximum does not include any amounts:

- resulting from the Member's failure to comply with HPN's Managed Care Program, including the inappropriate use of an emergency room facility for a condition which does not require Emergency Services;
- in excess of Eligible Medical Expenses;
- for services that are not Covered Services;
- for services that are not Prior Authorized through HPN's Managed Care Program; or
- in excess of the Calendar Year, per Illness or any other benefit maximums as set forth in Attachment A Benefit Schedule.

12.15 **"Claim For Benefits"** means a request for a Plan benefit or benefits made by a Member in accordance with the Plan's Appeals Procedures, including any Pre-Service Claims (requests for Prior Authorization) and Post-Service Claims (requests for benefit payment).

12.16 **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

12.17 **"Coated Lenses"** means a substance which is added to a finished lens on one or both surfaces.

12.18 **"Coinsurance"** means the percentage of the charges billed or the percentage of Eligible Medical Expenses, whichever is less, that a Member must pay a Provider

for Covered Services. Coinsurance amounts are to be paid by the Member directly to the Provider who bills for the Covered Services. (See Attachment A, Benefit Schedule.)

12.19 **"Complications of Pregnancy"** means:

- conditions with diagnoses which are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia, and missed abortion;
- a non-elective cesarean section;
- terminated ectopic pregnancy; or
- spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does NOT include (1) false or premature labor; (2) occasional spotting; (3) prescribed rest during the period of pregnancy; or (4) similar conditions associated with the management of a difficult or high risk pregnancy not constituting a distinct Complication of Pregnancy.

12.20 "**Contact Lenses"** means ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted directly to the patient's eyes.

12.21 **"Convenient Care Facility"** means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:

1. diagnostic laboratory services;
2. general health screenings;
3. minor wound treatment and repair;
4. minor illnesses (cold/flu);
5. treatment of burns and sprains;
6. blood pressure checks

12.22 **"Copayment" or "Cost-share"** means the amount the Member pays when a Covered Service is received.

12.23 **"Covered Services"** means the health services supplies and accomodations, for which HPN pays benefits under this Plan.

12.24 **"Covered Transplant Procedures"** means any Medically Necessary, human-to-human, organ or tissue transplants performed upon a Member who satisfies medical criteria developed by HPN for receiving transplant services. It includes any transplant procedures for which coverage is required by federal regulation.

12.25 **"Custodial Care"** means care that mainly provides room and board (meals) for a physically or mentally disabled person. Such care does not reduce the disability so that the person can live outside a Hospital or nursing home. Examples of Custodial Care include:

- Non-Skilled Nursing Care.
- Training or assistance in personal hygiene.
- Other forms of self-care.
- Supervisory care by a Physician in a custodial facility to meet regulatory requirements.

12.26 **"Deductible"** means the portion of Eligible Medical Expenses, excluding Copayments, that a Member must pay, either in the aggregate or for a particular service, before HPN will make any benefit payments for Covered Services. (See Attachment A Benefit Schedule.)

12.27 **"Dependent"** means an Eligible Family Member of the Subscriber's family who:

- meets the eligibility requirements of the Plan as set forth in Section 1 of this AOC;
- is enrolled under this Plan; and
- for whom premiums have been received and accepted by HPN.

12.28 **"Durable Medical Equipment" or "DME"** means medical equipment that:

- can withstand repeated use;
- is used primarily and customarily for a medical purpose rather than convenience or comfort;
- generally is not useful to a person in the absence of an Illness or Injury;
- is appropriate for use in the home; and
- is prescribed by a Physician.

12.29 **"Effective Date"** means the initial date on which Members are covered for services under this Plan provided any applicable premiums have been received and accepted by HPN.

12.30 **"Eligible Family Member"** means a member of a Subscriber's family that is or becomes eligible to enroll for coverage under this Plan as a Dependent.

12.31 **"Eligible Medical Expenses"or "EME"** means the maximum amount HPN will pay for a particular Covered Service as determined by HPN in accordance with HPN's Reimbursement Schedule.

12.32 **"Eligible Vision Expenses" (EVE)** means the maximum allowable amount the Company will pay for a particular Covered Service as determined by the Company in accordance with the HPN Reimbursement Schedule. Vision Plan Providers have agreed to accept the HPN Reimbursement Schedule as payment in full for Covered Services, less any applicable Copayment. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

12.33 **"Emergency Dental Services"** means Covered Services provided after the sudden onset of a dental condition with symptoms severe enough to cause a

prudent person to believe that lack of immediate medical attention could result in serious:

- jeopardy to his health;
- jeopardy to the health of an unborn child;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

12.34 **“Emergency Services”** means Covered Services provided after the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious:

- jeopardy to his health;
- jeopardy to the health of an unborn child;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

12.35 **“Enrollment Date”** means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period.

12.36 **“ERISA”** means Employee Retirement Income Security Act of 1974, as amended, including regulations implementing the Act.

12.37 **“Essential Benefits”** include the following: ambulatory services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services; including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

12.38 **“Expedited Appeal”** means if a Member appeals a decision regarding a denied request for Prior Authorization (Pre-Service Claim) for an Urgent Care Claim, the Member or Member’s Authorized Representative can request an Expedited Appeal, either orally or in writing. Decisions regarding an Expedited Appeal are generally made within seventy-two (72) hours from the Plan’s receipt of the request.

12.39 **“External Review”** means an independent review of an Adverse Benefit Determination conducted by an External Review Organization.

12.40 **“Family Members”** means members of the Subscriber’s family who meet the eligibility requirements of the Agreement and are enrolled according to the terms of the Agreement and for whom premiums have been received by HPN. For the purposes of this Agreement, Family Members may also be referred to as “Dependents”.

12.41 **“Final Adverse Benefit Determination”** means the upholding of an Adverse Benefit Determination at the conclusion of the internal appeals process or an Adverse Benefit Determination in which the internal appeals process has been deemed exhausted.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service.

12.42 **“Frames”** means standard eyeglass Frames adequate to hold two Lenses.

12.43 **“Free Standing Diagnostic Center”** means a licensed establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient diagnostic services.

12.44 **“Genetic Disease Testing”** means the analysis of human DNA, chromosomes, proteins or other gene products to determine the presence of disease related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risks, identification of carriers, monitoring, diagnosis or prognosis, but do not include tests conducted purely for research.

12.45 **"Habilitative Services"** means occupational therapy, physical therapy and speech therapy prescribed by the Member's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Member prior to that Member developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

12.46 **“Health Benefit Plan”** means a policy, contract, certificate or agreement offered by a carrier, or similar agreement offered by an employer or other legal entity, to provide for, arrange for payment of, pay for or reimburse any of the costs of healthcare services. This term includes Short-Term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis. Health Benefit Plans do not include:

- Coverage for accident only, dental only, vision only, disability income insurance, long-term care only insurance, hospital indemnity coverage or other fixed indemnity coverage, limited benefit coverage, specific disease/Illness coverage, credit-only insurance;

- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation insurance;
- Coverage for medical payments under a policy of automobile insurance;
- Coverage for on-site medical clinics; or
- Medicare supplemental health insurance.

12.47 **"Health Maintenance Organization" or "HMO"** means an organization that is formed in accordance with state law to provide managed healthcare services.

12.48 **"Health Plan of Nevada" or "HPN"** means Health Plan of Nevada, Inc., a Nevada corporation licensed by the Nevada Insurance Commissioner under Nevada law. HPN is a federally qualified Health Maintenance Organization.

12.49 **"HPN Reimbursement Schedule"** means the schedule showing the amount HPN will pay for Eligible Medical Expenses (EME) to Providers. EME will be applicable to Non-Plan Providers including Non-Plan Facilities. HPN Reimbursement Schedule is based on:

- the amount most consistently paid to the Provider; or
- the amount paid to other Providers with the same or similar qualifications; or
- the relative value and worth of the service compared to other services which HPN determines to be similar in complexity and nature with reference to other industry and governmental sources, examples of these sources include published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar services within the geographic market, a gap methodology, or Eligible Medical Expense could be based on a percentage of the provider's billed charge.

For Non-Plan Provider Emergency Services, HPN will pay the greater of:

- the amount we have negotiated with Plan Providers for the Emergency Services received (and if there is more than one amount, the median of the amounts); or
- 100% of the Eligible Medical Expense for Emergency Services provided by a Non-Plan Provider under your Plan; or
- the amount that would be paid for the Emergency Services under Medicare.

12.50 **"Home Healthcare"** means healthcare services given by a Home Healthcare agency, under a Physician's orders in the person's home. It is care given to persons who are homebound for medical reasons and physically not able to obtain necessary medical care on an outpatient basis. A Home Healthcare agency must be licensed by the state where it is located.

12.51 **"Hospice"** means an establishment licensed by the state where it is located that furnishes a centrally administered program of palliative and supportive services. Such services are provided by a team of healthcare Providers and directed by a Physician. Services include physical, psychological, custodial and spiritual care for patients who are terminally ill and their families. For the purposes of this benefit only, "family" includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.

12.52 **"Hospice Care Services"** means acute care provided by a Hospice if the Member has less than six (6) months to live as certified by the treating Physician, and the Member is not receiving or intending to receive any curative treatment. Care may be provided in the home, at a residential facility or at a medical facility at any time of the day or night. These services include bereavement care provided to the patient's family after the patient dies.

12.53 **"Hospital"** means a facility that:

- is licensed by the state where it is located and is Medicare-certified;
- provides 24-hour nursing services by registered nurses (RNs) on duty or call; and
- provides services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions.

Hospital does not include:

- residential or nonresidential treatment facilities;
- health resorts;
- nursing homes;
- Christian Science sanataria;
- institutions for exceptional children;
- Skilled Nursing Facilities, places that are primarily for the care of convalescents;
- clinics;
- Physician offices;
- private homes; or
- Ambulatory Surgical Facilities.

12.54 **"Illness"** means an abnormal state of health resulting from disease, sickness or malfunction of the body; or a congenital malformation which causes functional impairment. For purposes of this AOC, Illness also includes sterilization or circumcision. Illness does not include any state of mental health or mental disorder other than Mental Illness as it is defined in this AOC.

12.55 **"Independent Medical Review"** means an independent evaluation of the medical or chiropractic

care of a Member that must include a physical examination of the Member unless he is deceased, and a personal review of all x-rays and reports by a certified Physician or Chiropractor who is formally educated in the applicable medical field.

12.56 **“Independent Review Organization”** means an entity that:
- Conducts an independent External Review of an adverse determination; and
- Is certified by the Nevada Commissioner of Insurance

12.57 **“Initial Enrollment Period”** means the period of time during which an eligible person may enroll under this Plan.

12.58 **“Injury”** means physical damage to the body inflicted by a foreign object, force, temperature, or corrosive chemical.

12.59 **“Inpatient”** means being confined in a Hospital or Skilled Nursing Facility as a registered bed patient under a Physician's order.

12.60 **“Lenses”** mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Vision Plan Provider to be fitted into frames.

12.61 **“Licensed Assistant Behavior Analyst”** means a person who holds current certification or meets the standards to be certified as a board certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an Assistant Behavior Analyst by the Board of Psychological Examiners and who provides Behavioral Therapy under the supervision of a Licensed Behavior Analyst or psychologist.

12.62 **“Licensed Behavior Analyst”** means a person who holds current certification or meets the standards to be certified as a board certified Behavior Analyst or a board certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and whom the Board of Psychological Examiners licenses as a Behavior Analyst.

12.63 **“Low Vision”** means a significant loss of vision but not total blindness.

12.64 **“Managed Care Program”** means the process that determines Medical Necessity and directs care to the most appropriate setting to provide quality care in a cost-effective manner, including Prior Authorization of certain services.

12.65 **“Manual Manipulation”** means the diagnosis, treatment or maintenance by a Practitioner for the treatment of:
- musculoskeletal strain surrounding vertebra, spine, broken neck; or
- subluxation of verterbra.

Manual Manipulation does not include diagnosis or treatment requiring general anesthesia, surgery or Hospital confinement.

12.66 **“Medical Director”** means a Physician named by HPN to review use of health services by Members.

12.67 **“Medically Necessary”** means a service needed to improve a specific health condition or to preserve the Member’s health and which, as determined by HPN is:
- consistent with the diagnosis and treatment of the Member’s Illness or Injury;
- the most appropriate level of service which can be safely provided to the Member; and
- not solely for the convenience of the Member, the Provider(s) or Hospital.

In determining whether a service or supply is Medically Necessary, HPN may give consideration to any or all of the following:
- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in peer-review literature;
- evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific date;
- professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- the opinions of independent expert Physicians in the health specialty involved when such opinions are based on broad professional consensus; or
- other relevant information obtained by HPN.

When applied to Inpatient services, “Medically Necessary” further means that the Member’s condition requires treatment in a Hospital rather than in any other setting. Services and accommodations will not automatically be considered Medically Necessary simply because they were prescribed by a Physician.

12.68 **“Medically Necessary for External Review”** means healthcare services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Illness, Injury or disease or any symptoms thereof that are necessary and:
- Provided in accordance with generally accepted standards of medical practice;
- Clinically appropriate with regard to type, frequency, extent, location and duration;
- Not primarily provided for the convenience of the patient, Physician or other Provider of healthcare;
- Required to improve a specific health condition of a Member or to preserve his existing state of health; and
- The most clinically appropriate level of healthcare that may be safely provided to the Member.

12.69 **"Medicare"** means Medicare Part A or Medicare Part B healthcare benefits that a Member is receiving under Title XVIII of the Social Security Act of 1965 as amended.

12.70 **"Member"** means a person who meets the eligibility requirements of Section 1, who has enrolled under this Plan and for whom premiums have been received and accepted by HPN.

12.71 **"Mental Illness"** means a pathological state of mind producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning where improvement can reasonably be anticipated with therapy.

Mental Illness does not include the following when they represent the primary need for therapy:

- marital or family problems;
- social, occupational, or religious maladjustment;
- Behavior disorders
- Impulse control disorders
- learning disabilities;
- mental retardation;
- chronic organic brain syndrome; or
- personality disorder.

12.72 **"Non-Plan Provider"** means a Provider who does not have an independent contractor agreement with HPN.

12.73 **"Occupational"** with respect to any Illness or Injury means any Illness or Injury arising out of or in the course of employment for pay or profit.

12.74 **"Orthoptics"** means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binoncular vision.

12.75 **"Orthotic Device"** means an apparatus used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

12.76 **"Oversize Lenses"** means large than standard lens blank, to accommodate prescriptions.

12.77 **"Photochromic Lenses"** means lenses which change color with intensity of sunlight.

12.78 **"Physician"** means anyone qualified and licensed to practice medicine and surgery by the state where the practice is located who has the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO). Physician also means doctors of Dentistry and Podiatric Medicine or a Chiropractor when they are acting within the scope of their license.

12.79 **"Physician Extender/Physician Assistant"** means a healthcare provider who is not a physician (MD/DO) but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.

12.80 **"Placed (or Placement) for Adoption"** means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person ends upon the termination of such legal obligation.

12.81 **"Plan"** means this Agreement of Coverage (AOC), including the Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, the Member's Enrollment Form, health statements, the Member Identification Card, and all other applications received by HPN.

12.82 **"Plano Lenses"** means lenses which have no refractive power.

12.83 **"Plan Provider"** means a Provider who has an independent contractor agreement with HPN to provide certain Covered Services to Members. A Plan Provider's agreement with HPN may terminate, and a Member will be required to select another Plan Provider.

12.84 **"Post-Service Claim"** means any Claim for Benefits under a Health Benefit Plan regarding payment of benefits that is not considered a Pre-Service Claim or an Urgent Care Claim.

12.85 **"Practitioner"** means any person(s) qualified and licensed to practice the healing arts when they are acting within the scope of their license.

12.86 **"Prescription Drug"** means a Federal Legend drug or medicine that can only be obtained by a prescription order or that is restricted to prescription dispensing by state law. It also includes insulin and glucagon.

12.87 **"Pre-Service Claim"** means any Claim for Benefits under a Health Benefit Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

12.88 **"Primary Care Physician" or "PCP"** means a Plan Provider who has an independent contractor agreement with HPN to assume responsibility for arranging and coordinating the delivery of Covered Services to Members. A Primary Care Physician's agreement with HPN may terminate. In the event that a Member's Primary Care Physician's agreement terminates, the Member will be required to select another Primary Care Physician.

12.89 **"Prior Authorization" or "Prior Authorized"** means a system that requires a Provider to get approval from HPN before providing non-emergency healthcare services to a Member in order for those

services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.

12.90 **"Procurement"** means obtaining Medically Necessary human organs or tissue for a Covered Transplant Procedure as determined by HPN and includes donor search, testing, removal, preservation and transportation of the donated organ or tissue. Procurement will also apply to medically appropriate donor testing services including, but not limited to, HLA typing, subject to any maximum procurement benefit amount. Procurement does not include maintenance of a donor while the Member is awaiting the transplant.

12.91 **"Professional Vision Services"** means examination, material selection, fitting of glasses, related adjustments, etc.

12.92 **"Prosthetic Device"** means a non-experimental device that replaces all or part of an internal or external body organ or replaces all or part of the function of a permanently inoperative or malfunctioning internal or external organ.

12.93 **"Provider"** means a:

- Hospital,
- Skilled Nursing Facility,
- Urgent Care Facility,
- Ambulatory Surgical Facility,
- Physician,
- Practitioner,
- dentist,
- podiatrist, or
- other person or organization licensed by the state where his practice is located to provide medical or surgical services, supplies, and accommodations acting within the scope of his license.

12.94 **"Qualified Health Plan"** means a plan approved by the Nevada Division of Insurance to be offered on the Federally Facilitated Marketplace.

12.95 **"Referral"** means a recommendation for a Member to receive a service or care from another Provider or facility.

12.96 **"Retransplant"** means the retransplantation of a previously transplanted organ or tissue.

12.97 **"Retrospective" or "Retrospectively"** means a review of an event after it has taken place.

12.98 **"Rider"** means a provision added to the agreement or the AOC to expand benefits or coverage.

12.99 **"Service Area"** means the geographical area where HPN is licensed to operate. It is shown in Attachment B. Subscribers must live or work in the Service Area to be covered under this Plan. Dependent children that are covered under this Plan, due to a court order, do not have to reside within the Service Area.

12.100 **"Severe Mental Illness"** means any of the following Mental Illnesses that are biologically based and for which diagnostic criteria are prescribed in the Diagnostic and Statistical Manual of Mental Disorder (DSM), fourth edition, published by the American Psychiatric Association:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder

12.101 **"Short-Term"** means the time required for treatment of a condition that, in the judgment of the Member's PCP and HPN, is subject to significant improvement within sixty (60) consecutive calendar days from the first day of treatment.

12.102 **"Short-Term Rehabilitation"** means Inpatient or outpatient rehabilitation services which are provided within the applicable number of visits as set forth in the Plan's Attachment A Benefit Schedule. This includes speech therapy, occupational therapy and physical therapy.

12.103 **"Skilled Nursing Care"** means services requiring the skill, training or supervision of licensed nursing personnel.

12.104 **"Skilled Nursing Facility"** means a facility or distinct part of a facility that is licensed by the state where it is located to provide Skilled Nursing Care instead of hospitalization and that has an attending medical staff consisting of one or more Physicians.

12.105 **"Specialist Physician" or "Specialist"** means a Plan Provider who has an independent contractor agreement with HPN to assume responsibility for the delivery of specialty medical services to Members. These specialty medical services include any Physician services not related to the ongoing primary care of a patient. A Specialist Physician's agreement with HPN may terminate. In the event that a Member's Specialist Physician's agreement terminates, another Specialist Physician will be selected for the Member if those services are still required.

12.106 **"Specialty Drugs"** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by HPN's P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

12.107 **"Subscriber"** means an individual who meets the eligibility requirements of this Plan, and who has

enrolled under the Plan, and for whom premiums have been received and accepted by HPN.

12.108 "Summary of Benefits" ("SBC") means a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The SBC helps consumers better understand the coverage they have and allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions and coverage limitations and exceptions. Members will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year and within seven business days of requesting a copy from their insurance issuer or group health plan.

12.109 "Telemedicine" means certain Covered Services for diagnosis and treatment of low acuity medical conditions delivered to HPN Members through the use of interactive audio, video, or other telecommunications or electronic technology by a contracted HPN Telemedicine Provider listed as such in the HPN Provider Directory at a site other than the site at which the patient is located. Telemedicine is available in all states where HPN contracted Telemedicine Providers offer telemedicine services. Telemedicine does not include the use of standard telephone calls, facsimile transactions or e-mail messaging and is only available through designated providers listed as Telemedicine Providers in the HPN Provider Directory.

12.110 "Therapeutic Supply" is the maximum quantity of supplies for which benefits are available for a single applicable Copayment or Coinsurance amount, if applicable, and may be less than but shall not exceed a thirty (30) day supply.

12.111 "Tinted Lenses" means lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).

12.112 "Transplant Benefit Period" means the period beginning with the date the Member receives a written Referral from HPN for care in a Transplant Facility and ending on the first of the following to occur:

- the date 365 days after the date of the transplant; or
- the date when the Member is no longer covered under this Plan.

12.113 "Transplant Facility" means a Hospital that has an independent contractor agreement or other contractual relationship with HPN to provide Covered Services to Eligible Members in connection with organ or tissue transplants related to a Covered Transplant Procedure as defined in this AOC. Non-Plan Hospitals do not have any contractual relationship with HPN to provide such services.

12.114 "Vision Plan Provider" means a Provider who has an independent contractor agreement with HPN to provide certain Covered Services to Members. A Vision Plan Provider's agreement with HPN may terminate, and a Member will be required to select another Vision Plan Provider.

12.115 "Urgent Care Claim" means a Claim for Benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not Urgent Care Claims could seriously jeopardize the Member's life, health or the ability to regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a Claim for Benefits that, in the opinion of a Physician with knowledge of the Member's medical conditions, would subject the Member to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for Prior Authorization of an Urgent Care service was denied, the Member could request an Expedited Appeal for the Urgent Care Claim.

12.116 "Urgent Care Facility" means a facility equipped and operated mainly to give immediate treatment for an acute Illness or Injury.

12.117 "Urgently Needed Services" means Covered Services needed to prevent a serious deterioration in a Member's health. While not as immediate as Emergency Services, these services cannot be delayed until the Member can see a Plan Provider.