Prominence℠
Preferred Health Insurance Company, Inc.

Prominence Preferred Health Insurance Company
Certificate of Coverage

YOUR SMALL GROUP CERTIFICATE OF COVERAGE

This is Your Group Certificate of Coverage (COC) with Prominence Health Insurance Company, Inc. (herein referred to as "PPHIC"), 1510 Meadow Wood Lane, Reno, Nevada, 89502, 775.770.9312.

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

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

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

If You have questions about this COC, please call a PPHIC Customer Service Representative at 775.770.9312 or 800.433.3077 or (TTY Operator Assistance) 800.326.6868. Our website, www.prominencehealthplan.com, also serves as an important resource for Your COC, provider directories, urgent care and emergency care locations and more.

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

State of Nevada Division of Insurance
Carson City Office
Phone: 775.687.0700
Fax: 775.687.0787
Consumer Compliance & Licensing
Fax: 775.687.0797
1818 E. College Pkwy., Suite 103
Carson City, Nevada 89706

Las Vegas Office

Phone: 702.486.4009
Fax: 702.486.4007
2501 East Sahara Avenue
Suite 302
Las Vegas, NV 89104
Division of Insurance Toll Free: 888.872.3234

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Language Translation Services

If you or someone you are assisting has questions about your health benefits or other information related to your plan coverage, you have the right to receive help and information in a language other than English at no cost. Please call Prominence Health Plan Customer Service at 775.770.9312 or 800.433.3077 and they can assist you with access to language translation services. You can also contact Customer Service to ask for the translation of written benefit materials. TTY/TDD services are available by dialing 800.326.6868.

Secure Online Member Portal

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

SYSTEM FEATURES

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

CURRENT MEMBERS

To access the secure online Member portal, visit www.prominencehealthplan.com.

If You have forgotten Your password, select “Forgot username or password?” and follow the screen prompts.

NEW USER REGISTRATION

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

- Visit www.prominencehealthplan.com.
- Select “Create an Account”
- Secure Online Member Portal link
- Access Your Plan Benefits
- Create an Account and complete the process

Once the log-in process has verified Your demographics, Your log-in and password will be directed to the member portal and You will have access to the online self-service benefit information.

FOR ASSISTANCE

If You need assistance setting up Your log-in or password, please contact:

Prominence Health Plan Customer Service
775.770.9312 or 800.433.3077
Monday through Friday, 8 a.m. to 5 p.m.

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Abbreviations Key

ADEA - Age Discrimination in Employment Act

COB - Coordination of Benefits

COC - Certificate of Coverage

COE - Center of Excellence

DME - Durable Medical Equipment

EME - Eligible Medical Expense

ERISA - Employment Retirement Income Security Act

ESRD - End Stage Renal Disease

FDA - U.S. Food and Drug Administration

HC - Health Choice

IPA - Independent Practice Association

NCQA - National Committee for Quality Assurance

OCHA – Office for Consumer Health Assistance

PHCN - Preferred Healthcare Network

PCP - Primary Care Practitioner

PHSA - Public Health Services Act

PPO - Preferred Provider Organization

QI - Quality Improvement

SOB - Summary of Benefits

TMJ - Temporomandibular Joint Disorder

TPN - Total Parenteral Nutrition

UM – Utilization Management

Para obtener asistencia en Español, llame al: 775.770.9312 / 800.433.3077. Los avisos están también disponibles en Español a petición.

Part I. Definitions

1. **Accessibility -** the extent to which a Member of PPHIC can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment.
2. **Accident Injury -** bodily injuries which are sustained as a direct result of an unintended, unanticipated event that is external to the body and that occurs while the injured person's coverage under the COC is in force; and which directly (independent of sickness, disease, mental incapacity, bodily infirmity or other cause) causes a covered loss. Bodily injuries include, but are not limited to, fractures, lacerations, burns, sprains, ingesting poison and concussions.
3. **Accidental Dental Injury** means a bodily injury which can be seen or felt by a Physician or which shows up on an x-ray or other diagnostic-imaging device. The bodily injury must have been caused by an accident. Accidental Dental Injury does not mean bodily injury caused by routine body movements such as stooping, twisting, bending or chewing and does not include damage to appliances or prosthetic devices. Treatment and repair must begin within six months of the date of a documented injury and must be prior authorized by PPHIC
4. **Acupuncture -** is considered an Alternative Medicine and is the piercing of peripheral nerves with needles to relieve the discomfort of painful disorders and/or for therapeutic purposes.
5. **Acute -** an illness or injury of short duration and generally of sudden onset and infrequent occurrence.
6. **Adverse Benefit Determination -** An Adverse Benefit Determination eligible for "internal" claims and appeals process includes, but is not limited to a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or a failure to provide or make a payment (in whole or in part) for a benefit is based on, among other things:
    - A determination that an individual is not eligible for coverage (e.g., rescission), or
    - The refusal to pay a claim, in whole or in part, due to the terms of coverage document regarding copays, deductibles, or other cost sharing requirements.
7. **Allowable Dental Expenses** means the maximum allowable amount that PPHIC will pay for a particular Covered Service as determined by PPHIC in accordance with the Reimbursement Schedule. In no event will PPHIC pay more than the maximum payment allowance established in the Reimbursement Schedule except as may be provided under the medical plan maximum out of pocket limitations.
8. **Alternative Medicine -** Approaches to medical diagnostic and therapy that have not been developed by use of generally accepted scientific methods. Forms of Alternative Medicine include acupressure, acupuncture, aroma therapy, ayurveda, biofeedback, herbal medicine, holistic medicine, homeopathy and hypnosis.
9. **Anniversary or Anniversary Date -** the annual date, every 12 months, upon which the coverage under this COC renews for another 12-month period.
10. **Anorexia Nervosa -** a condition characterized by a refusal to maintain a minimally normal body weight.
11. **Appeal -** a written request to PPHIC to change an Adverse Benefit Determination.
12. **Authorization -** the process by which an In-Network Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Medical Plan Member and obtain approval from the Medical Plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment; payment is dependent upon eligibility at the time Covered Services are received.
13. **Authorized Representative -** A person to whom a covered person has given (a) express written consent to represent the covered person in an external review of an adverse determination; (b) A person authorized by law to provide substituted consent for a covered person; or (c) A family member of a covered person or the covered person's treating provider only when the covered person is unable to provide consent.
14. **Autism Spectrum Disorder -** is a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.

15. **Availability -** the extent to which the Medical Plan has Practitioners/Providers of the appropriate type and number distributed geographically to meet the needs of its membership.
16. **Bariatric Restrictive Services -** includes various surgical interventions to accomplish weight-loss reduction in individuals who meet the criteria.
17. **Benefit** means the amount payable in accordance with the provisions of this plan.
18. **Bereavement Services -** care extended to the surviving family Members of a deceased person to help them navigate through the grieving process following the loss of a loved one. Bereavement Services generally include counseling and educational support to survivors through visits, phone calls, letter contact, or through support groups.
19. **Bulimia Nervosa -** a medical condition characterized by repeated episodes of binge eating followed by inappropriate compulsory behaviors such as self-induced vomiting, misuse of laxatives, misuse of diuretics, or other medications, fasting and/or excessive exercise.
20. **Calendar Year -** the 12-month period beginning January 1 and ending December 31.
21. **Cardiac Rehabilitation Services -** Phase I and Phase II includes Inpatient cardiac monitored services; programs are physician ordered and supervised.
22. **Centers of Excellence (COE) -** An approved Center of Excellence (COE) is a health care facility or practitioner that provides highly specialized care to Prominence members with certain health conditions. COE partner facilities or providers must meet PPHIC high standards for quality and value including demonstrated positive patient outcomes, cost-efficient health care delivery and compliance with rigorous quality control metrics.

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

    For more information about the COE program and all participating facilities, please visit www.prominencehealthplan.com.
23. **Certificate of Coverage COC or the Plan -** this document, the SOB, and any amendments that may be added in the future, which explain the services and benefits covered by PPHIC and defines the rights, responsibilities and accountabilities of the Member and PPHIC.
24. **Chelation Therapy -** the treatment and removal of lead poisoning or other heavy metal poisoning from the body.
25. **Children Under the Age of 26 -** The Affordable Care Act (ACA) requires that dependent children be covered up to age 26.
26. **Chronic/Supportive -** an illness or injury that is or expected to be, six (6) months or longer, and/or with frequent recurrences and is always more or less present. Chronic/Supportive conditions may have Acute episodes.
27. **Coinsurance -** the percentage of charges billed or the percentage of eligible medical expense charges whichever is less that a Member must pay an In-Network Practitioner/Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the In-Network Practitioner/Provider who bills for the Covered Services.
28. **Complaint -** an oral or written expression of dissatisfaction from a Member or Practitioner/Provider.
29. **Complex Diagnostic Testing -** diagnostic imaging and testing including, but not limited to PET Scans, Stress tests, Complex Echocardiography, Complex Duplex Scans, Sleep Studies, Seizure Monitoring, Complex Angiography, Complex Aortography, Complex Musculoskeletal imaging and SPECT scans. This category of imaging does not include screening and diagnostic mammography, x-ray, ultrasound, MRI and CT scans, and basic diagnostic testing.
30. **Compression Stockings -** various graded stretch material to create compression.
31. **Congenital -** existing at or dating from birth, acquired during development in the uterus.

32. **Contraceptive Methods -** All Food and Drug Administration (FDA) approved contraceptive methods prescribed by a women's doctor are covered.
33. **Coordination of Benefits (COB) -** a process by which another group health plan (if the Member is enrolled on both this PPHIC Medical Plan and another group health plan) may be responsible for claims payment either as the primary or secondary carrier.
34. **Copayment -** the amount paid by You directly to the healthcare In-Network Practitioner/Provider at the time the services are received. These Copayments are described in the SOB, a separate document, which is supplied to the Subscriber.
35. **Cosmetic -** procedures which are performed primarily to improve or change physical appearance or bodily form, but which do not correct or materially improve a physiological function.
36. **Cosmetic Dentistry** means services that are provided by a Dentist primarily for the purpose of improving appearance.
37. **Course of Treatment** means an interdependent series of Medically Necessary Dental Covered Services prescribed by a Dentist to correct a specific dental condition.
38. **Covered Dental Services** means those dental related services or supplies to which eligible dependent children are entitled as shown in Summary of Benefits and Part XIX of this Schedule of Covered Services.
39. **Covered Services -** those Medically Necessary medical and Hospital services described in this COC, which, for the purpose of preventing, alleviating, curing or healing illness or injury, are provided to Members.

    While Covered Services must always be Medically Necessary, not every Medically Necessary service is a Covered Service.
40. **Schedule of Covered Services** means this document, the Group Enrollment Agreement, Summary of Benefits and any attachments or endorsements thereto, the Insureds identification card, application and supplemental applications to PPHIC for dental care benefits.
41. **CT Scan -** computerized axial tomography scan is more commonly known by its abbreviated name, CT Scan. It is an x-ray that combines many x-ray images with the aid of a computer to generate cross-sectional views and, if needed, three-dimensional views of organs and structures of the body.
42. **Custodial Care -** healthcare services or other related services which:
    a. Does not seek a cure;
    b. Are provided during periods when Acute care is not required or when the medical condition of a member is not changing;
    c. Does not require continued administration by licensed medical personnel;
    d. Assists in the activities of daily living.
43. **Deductible -** a set amount of covered charges occurring each Calendar Year which must be paid by the Member before benefits are payable under this Medical Plan. Copays do not count towards the deductible; copays do count towards the out-of-pocket maximum.
44. **Dental Injury -** an injury to the jaw, sound natural teeth, mouth or face as a result of an accident caused by an external force such as a blow or fall. An injury that results from chewing or biting is not considered an accidental dental injury.
45. **Dentist** means an individual who is duly licensed to practice dentistry or perform oral surgery and is acting within the lawful scope of his or her license.
46. **Dependent -** any Member of the Subscriber's family who meets the eligibility for coverage as defined in this COC and enrolled by the Subscriber.
47. **Developmental Delay -** when a Member has not reached the appropriate level of intellectual, speech, motor or physical development normally expected for the Members age, and such conditions are not a result of an injury or illness.
48. **Diagnostic Services -** Medically Necessary tests performed to aid in the diagnosis or detection of disease. Diagnostic testing is essential to the basic management of patient care, allowing physicians

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

49. **Disability -** the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

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

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

    a. Designed and able to withstand repeated use;

    b. Used primarily and customarily for a medical purpose;

    c. Is generally not useful to a Member in the absence of an Illness or Injury; and

    d. Suitable for use in the home.

52. **Effective Date** means the date specified by PPHIC as the date Insureds are covered under the terms of this Schedule of Covered Services provided the premium has been received by PPHIC.

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

54. **Emergency Dental Services** means services required for the relief of severe pain or bleeding, and/or the immediate diagnosis and treatment of an unforeseen dental condition, which, if not treated immediately, would result in serious harm to the dental health of the member. Coverage for an emergency is limited to palliative care only.

55. **Emergency Services**

    a. A Prior Authorization may be required, even for Out-of-Network services

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

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

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

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

56. **Employee** means a person who is designated as being eligible for coverage in the Group Enrollment Agreement and who meets all the applicable eligibility requirements of this Schedule of Covered Services, whose enrollment form has been accepted by PPHIC in accordance with the enrollment requirements of this Schedule of Covered Services and for whom premiums have been received by PPHIC.

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

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

59. **Expense Incurred Date** means the date on which:
    a. The teeth are prepared for fixed bridges, crowns, inlays or onlays;
    b. The final impression is made for dentures or partials;
    c. The pulp chamber of a tooth is opened for root canal therapy;
    d. Periodontal surgery is performed;
    e. The service is performed for services not listed above.

60. **Experimental/Investigational -** a drug, device, medical treatment or procedure that in PPHIC's sole discretion meets any of the following:
    a. The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
    b. The informed consent document utilized with the drug, device, medical treatment or procedure indicates that such drug, device, medical treatment or procedure is experimental/investigational;
    c. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;
    d. Unless otherwise mandated by State and Federal Statutes.
61. **External Review Organization -** is a medical review performed by an independent review organization or specialist.
62. **Grace Period -** the 30-day period from the date Premium payment is due until it is considered delinquent. During the Grace Period coverage remains in effect.
63. **Group -** the employer or other party that has entered into a Group Contract with PPHIC through which benefits under this COC are provided to eligible employees, and the employer has agreed to collect and pay Premiums. The Group is not an agent of PPHIC, but is considered the plan sponsor.
64. **Group Contract -** the agreement between the Group and PPHIC through which the Health Plan coverage for eligible employees and Dependents is elected.
65. **Group Open Enrollment Period -** those periods of time established by the Group and PPHIC during which eligible persons who have not previously enrolled with PPHIC may do so. The enrollment period will be established at least once every 12 months, for a period of no less than 15 days.
66. **Habilitative Services -** health care services that help a person keep, learn, or improve skills and functioning for daily living. Services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and outpatient settings.
67. **Health Information - 24-Hour Nurseline -** Members have free access to Our Health Information/24-hour NurseLine. They can call about health-related problems, accidents, or to ask health-related questions. The NurseLine team is staffed with experienced health specialists and registered nurses who are able to assist members in determining the safest, most appropriate level of care, including self-care options and next steps. Member ID cards should be accessible when placing a call to the NurseLine, as health plan membership will need to be verified by the NurseLine staff during the call. Members can call the NurseLine toll free at 800.243.5495
68. **Home Health Agency -** an agency that provides intermittent Skilled Nursing Services and other therapeutic Medically Necessary Covered Services in Your home when You are confined to Your home, and when coordinated by an In-Network Practitioner/Provider.
69. **Hospital -** an Acute Care Hospital licensed by the State and approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or by the Medicare program. A Hospital is not a government Hospital, a place for rest, a place for the aged, or a nursing home.
70. **Hospital Outpatient Facility -** This facility conducts testing and ambulatory procedures and is owned and/or operated by a hospital. An additional share of cost may be required when a member chooses to receive elective care from a Hospital Outpatient Facility.
71. **Independent Review Organization (IRO) -** an entity that: (a) Conducts an independent external review of an Adverse Benefit Determination; and (b) is certified by the Nevada Division of Insurance Commissioner to do so.
72. **In-network -** A term for providers or facilities that enter into a network agreement with PPHIC.

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

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

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

76. **Medical Supplies** - Medical Supplies are routine supplies that are customarily used during the course of treatment for an Illness or Injury. Medical Supplies include, but are not limited to the following:
    a. Catheter and catheter supplies - Foley catheters, drainage bags, irrigation trays;
    b. Colostomy bags (and other ostomy supplies);
    c. Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lambs wool pads, sterile solutions, ointments, sterile applicators, sterile gloves;
    d. Elastic stockings;
    e. Enemas and douches;
    f. IV supplies;
    g. Sheets and bags;
    h. Splints and slings;
    i. Surgical face masks; and
    j. Syringes and needles.

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

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

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

    c. Not mainly for Your convenience or that of Your doctor or other health care provider; and

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

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

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

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

78. **Member -** any Subscriber or eligible enrolled Dependents entitled to benefits under this COC.

79. **Never Events -** are services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients.

    "Never Events" include, but are not limited to:

a. Serious preventable event - Air embolism

b. Serious preventable death - Blood incompatibility

c. Serious preventable event - object left during surgery

d. Catheter-associated Urinary tract infections

e. Pressure (Decubitus) ulcers

f. Vascular catheter - associated infection

g. Surgical site infection - Mediastinitis after coronary artery bypass graft (CABG) surgery.

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

80. **Non-Covered Services -** those services excluded from coverage pursuant to this COC.

81. **Non-Participating Provider -** a provider defined as one of the following:

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

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

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

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

83. **Orientation Period -** the 30-day reasonable and bona fide employment-based orientation period which precedes the 90-day waiting period.

84. **Oral Chemotherapy -** Coverage for orally administered chemotherapy for the treatment of cancer. PPHIC shall not (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

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

86. **Out-of-Network Services -** those Medically Necessary Covered Services provided outside the Preferred Health Care or Universal Health Network.

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

88. **Palliative Treatment** means treatment used in an emergency to relieve ease or alleviate the acute severity of dental pain, swelling or bleeding. Palliative treatment usually is performed for, but not limited to, the following acute conditions:
    a. Toothache;
    b. Localized infection;
    c. Muscular pain or Sensitivity and irritation of the soft tissue.
    Services are not considered palliative when used in association with any other covered services except X-rays and/or exams.

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

90. **Pediatric Dental Summary of Benefits** means the summary of covered services, benefit limitations & exclusions, coinsurance and deductibles provided to the Group.

91. **Plan Dentist** means a Dentist who has an independent contractor agreement with PPHIC to provide Covered Services to insured members.
92. **Pneumatic Compression Stockings -** the use of air to create compression.
93. **PPHIC -** PPHIC Prominence Preferred Health Insurance Company, Inc.
94. **PPO Provider -** A participating facility provider or a participating professional provider that has entered into an agreement with PPHIC to limit charges for services performed under this COC.
95. **Practitioner** means any person(s) qualified and licensed to practice within the dental profession when he is acting within the scope of his license, including a dental hygienist.
96. **Preferred Health Care Network (PHCN) -** a network of hospitals, physicians and other medical Providers participating as independent contractors.
97. **Premium -** the periodic payment, usually monthly, made to PPHIC by You, or on Your behalf, that entitles You to the benefits outlined in this COC.
98. **Pretreatment Estimate of Dental Benefits** means a written report or Treatment Plan prepared by your Dental Professional and submitted to PPHIC's for determination of the eligible dental benefits we would pay. We recommend your Dental Professional provide us a Treatment Plan when dental services and supplies may result in dental expenses of $300 or more.
99. **Preventive Care Services -** Preventive Care Services including physician exams, preventive screens (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services and HIV testing), and additional preventive care for women provided for in the guidelines supported by the U.S. Preventive Services Task Force. This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law - see the Preventive Health Guidelines at list at www.doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/.
100. **Primary Care Provider (PCP) -** A medical professional who assists a Member in identifying, preventing or treating an illness, injury or disability. Medical Plan Members have the right to designate any primary care provider who is a participating provider and who is available to accept You or Your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please call a PPHIC Customer Service Representative at 775.770.9312 or 800.433.3077. For children, a Member may designate a pediatrician as the primary care provider.
101. **Prior Authorization -** the process in which a Practitioner/Provider must justify the need for delivering a Covered Service or medication to a Plan Member and obtain approval from the Plan before actually providing the service as a condition of reimbursement. Authorization does not guarantee payment: payment is dependent upon eligibility at the time Covered Service is received. For a complete list of services requiring an authorization visit our website at www.prominencehealthplan.com. A Member does not need Prior Authorization from the Medical Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specialize in obstetrics or gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact PPHIC Customer Service at 775.770.9312 or 800.433.3077, or www.prominencehealthplan.com.
102. **Prior Deductible Credit -** When Members change to a PPHIC employer health coverage from another health insurance carrier's employer coverage, they may be eligible for prior in-network deductible credit upon initial enrollment. Prior deductible credit is the term used when claims for services or supplies that were applied toward the current deductible requirement of the prior carrier are applied to the deductible requirement of the PPHIC Coverage. Members must request prior deductible credit and submit written notification of such charges to PPHIC's customer service department no later than 180 days following the employer's effective date with PPHIC.
103. **Professional Services -** those Covered Services, except as excluded or limited in this Certificate of Coverage, performed by physicians and health professionals which are Medically Necessary and generally recognized as appropriate care within the Service Area and in accordance with PPHIC policies and procedures.

104. **Prohibition on Discrimination -** This COC prohibits discrimination in favor of highly compensated individuals as to Plan eligibility or Plan benefits.

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

106. **Provider Directory -** a list of PPHIC Plan Practitioners/Providers that provide Medically Necessary Covered Services to all Members. The Provider Directory can be provided upon enrollment, upon group renewal, upon request and at www.prominencehealthplan.com. The Provider Directory is provided to the Subscriber at the time of enrollment to assist Members with their selection of a provider for their healthcare services. Additions and changes are continuously made to the Provider Directory; therefore, to confirm a Practitioner's or Provider's participation with PPHIC contact Customer Service at 775.770.9312 or 800.433.3077 prior to receiving services. It should be noted that the Provider Directory represents a list of Practitioners which Prominence has a contractual relationship for the provision of medical services, but this list does not imply an employer/employee relationship between Prominence and the Practitioners.

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

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

109. **Rehabilitative Therapy -** physical, speech, occupational, cardiac, and pulmonary/respiratory therapy.

110. **Reimbursement Schedule** means the maximum allowable amount PPHIC will pay for a particular covered service based on the contracted amount with each preferred dental provider. For a nonpreferred Dentist, PPHIC will pay the percent shown in the Pediatric Dental Summary of Benefits based on the reimbursement schedule identified in Your Pediatric Dental Summary of Benefits. Charges billed by a non-preferred dentist that exceed the reimbursement limit will not apply to the member's deductible, coinsurance or maximum out of pocket expenses as provided by the medical plan.

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

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

113. **Respite Care** is the short-term, temporary relief to those who are caring for family Members.

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

115. **Schedule of Covered Pediatric Dental Services -** the schedule of approved Pediatric Dental Services is found in Part XIX of this document – Pediatric Dental Expenses & Services.

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

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

118. **Short Term Therapy -** therapy that is limited to treatment for conditions which are subject to significant clinical improvement within the period of time defined in this COC.
119. **Skilled Nursing Care -** services that can only be performed by, or under the supervision of, licensed nursing personnel.
120. **Skilled Nursing Facility (SNF) -** a facility which is licensed by the State of Nevada to provide inpatient medical and nursing care, and is recognized as such by Medicare. Care in a Skilled Nursing Facility is provided only if Hospitalization would otherwise be required. The term Skilled Nursing Facility does not include a convalescent nursing home, rest facility, or facility for the aged.
121. **Sound Natural Teeth -** teeth which:
    a. Are whole or properly restored;
    b. Are without impairment or periodontal disease; and
    c. Are not in need of the treatment provided for reasons other than Dental Injury.
122. **Specialty Drugs -** includes self-injectables and medications given by or other routes of administration. Specialty Drugs require the coinsurance listed on Your Summary of Benefits (SOB). Self-Injectables include combination therapy kits, which can be obtained from an outpatient pharmacy, and can be self-administered. Insulin is not considered a Specialty Drug. The list of Specialty Drugs can be found at www.prominencehealthplan.com. Contact Customer Service at 775.770.9312 or 800.433.3077 for more information.
123. **Speciality Pharmacy -** Some Specialty Drugs require the Member to obtain the drug through the PPHIC's Specialty Drug provider. Contact Customer Service at 775.770.9312 or 800.433.3077 for more information.
124. **Specialist -** a physician other than a Primary Care Physician who is participating in PPHIC and listed in the current Provider Directory. A Specialist should only be seen when coordinated by an In-Network Practitioner/Provider and may require a Prior Authorization by PPHIC, except in the case of Emergency Services.
125. **Subscriber -** a person who meets all eligibility requirements and has completed an enrollment form, has completed a health assessment form and/or provides certificate of creditable coverage, and has paid, or has paid on his or her behalf, all applicable Premiums. The Subscriber is the person to whom this COC is issued.
126. **Summary of Benefits SOB -** the summary of Covered Services, benefit limitations, Coinsurance (if applicable), and Deductibles that are provided to the Group.
127. **Telemedicine -** A delivery of healthcare services from a provider of healthcare to a patient at a different location through the use of technology that transfers information electronically, telephonically or by fiber optics, not including standard telephone, facsimile or electronic mail. The Provider must hold a valid license or certificate to practice his or her profession in this State.
128. **Total Parenteral Nutrition (TPN) -** the delivery of nutrients through an intravenous line directly into the blood stream.
129. **U.S. Food and Drug Administration (FDA) -** Protecting the public health by assuring that foods (except for meat from livestock, poultry and some egg products which are regulated by the U.S. Department of Agriculture) are safe, wholesome, sanitary and properly labeled; ensuring that human and veterinary drugs, and vaccines and other biological products and medical devices intended for human use are safe and effective.
130. **Urgent Care Services -** care for Medically Necessary Covered Services due to injury, illness or another type of condition, usually not life-threatening, which should be treated within 24 hours. Routine or follow-up care is not considered an Urgent Care Service.
131. **Waiting Period -** the waiting period is the time a Member must continuously work for the Group before the Member is eligible for coverage and must be not more than 90 days from the date the waiting period started. The 90 days is counted as calendar days not work days and coverage must begin on the 91st day of employment.

132. **We or Us or Our -** refers to Prominence Preferred Health Insurance Company, Inc. (PPHIC).

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

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

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

1. **Access to Obstetrical or Gynecological Care -** A Medical Plan Member does not need prior authorization from PPHIC or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact PPHIC Customer Service at 775.770.9312 and 800.433.3077.
2. **Guidance on Rescissions -** The Medical Plan will not rescind coverage once a Member is enrolled unless the individual (or a person seeking coverage on behalf of the individual) performs an intentional act, practice or omission that constitutes fraud, or unless the individual makes an intentional material misrepresentation of fact, as prohibited by the terms of the Certificate of Coverage. The Plan will provide at least 30 days advance written notice to each individual who would be affected before coverage will be rescinded.
3. **Coverage of Preventive Health Services -** The Plan provides preventive services such as mammograms, colonoscopies, cancer screenings, blood pressure and cholesterol tests, counseling to lose weight or quit smoking, health check-ups, and immunizations for children without cost-sharing by members. Preventive Health Services provided without cost-sharing include:
   a. Services recommended by the U.S. Preventive Services Task Force;
   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;
   c. Preventive Care and Screenings for infants, children and adolescents supported by the Health Resources and Services Administration;
   d. Preventive Care and Screenings for women supported by the Health Resources and Services Administration.
4. **Prohibition On Discrimination In Favor Of Highly Compensated Individuals -** The Plan prohibits discrimination in favor of highly compensated individuals as to plan eligibility or plan benefits.

Part III. Advance Directives: Making Your Health Care Wishes Known

Prominence Preferred Health Insurance Company, Inc. (PPHIC) is required by law to inform You of Your right to make healthcare decisions as well as Your right to execute advance directives. An advance directive is a formal document written by You in advance of an incapacitating illness or injury. As long as You can speak for Yourself, PPHIC Providers will honor Your wishes. If You become so sick that You cannot speak for Yourself, then this directive will guide Your healthcare providers in treating You and will save Your family, friends and physicians from having to guess what You would have wanted.

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

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

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

You should provide copies of Your completed directive to:

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

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

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

Part IV. Utilization Management and Quality Improvement Programs

1. UTILIZATION MANAGEMENT PROGRAM

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

Key components of Utilization Management (UM) include Prior Authorization, concurrent review (while You are receiving inpatient care) retrospective review, care coordination and case management. The Utilization Management staff works under the direct supervision of the Medical Director. Prominence Health Plan believes there is special concern regarding under utilization. Utilization Management review decisions are based only on appropriateness of care, services requested and existence of benefit coverage. PPHIC does not incentivize Practitioners/Providers or other individuals conducting utilization review for denials of coverage or service, nor does it provide financial incentives to those reviewing the cases to encourage denial determinations. Utilization Management staff provides telephonic coverage from 8 a.m. - 5 p.m. (normal business hours) Monday-Friday (normal business days), for callers with questions about the UM process. A toll-free number 800.433.3077 for inbound callers with questions about the UM process is also available. Utilization Management provides confidential voicemail 24 hours a day, seven days a week at 775.770.9312 and a confidential fax 24 hours a day, seven days a week at 775.770.9364. Referrals are not needed for specialty care by the plan.

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

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

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

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

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

Complex Care Coordination/Care Coordination is offered by PPHIC at PPHIC's discretion and is provided by a Registered Nurse; this process assists members who have complex medical, psychosocial and care coordination needs. Care Coordinators/Case Managers provide needed information and education to promote understanding, of the plan of care benefits available and resource utilization. This can help reduce the chance of further complications, and facilitate efficient and appropriate delivery of care and services.

Contacting Utilization Management: If You have any questions or wish to make a referral to Care Coordination/Case Management, please call our Central Intake line at 775.770.9247, Monday-Friday, excluding holidays

2. CARE COORDINATION SERVICES

Care Coordination can assist Members whose benefits are ending by providing alternatives and resources for continuing care and how to obtain it as appropriate.

Care Coordinators can also assist pregnant adolescents in their transition from Pediatrics to an Adult Primary Care Practitioner, OB/GYN, Family Practitioner or Interventionist.

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

3. QUALITY IMPROVEMENT PROGRAM

PPHIC Quality Improvement (QI) Program is designed to assess and improve the quality of care and service delivered to Medical Plan Members. The goal of the QI Program is to monitor the quality and appropriateness of patient care and service and to meet or exceed established local, State and national standards. Methods to achieve this include, but are not limited to, establishing standards and performance goals for the delivery of care and services, measuring performance outcomes and development and implementation of action plans to improve outcomes. The focus of the QI Program is to improve the overall health status of Medical Plan Members through systematic identification and review and evaluation of processes to achieve improvement. An appropriate balance between quality and quantity of health care will be achieved through a system of formalized objective evaluations. The comprehensive QI Program provides the framework for determining indicators for recommended levels of care and service. Opportunities for improvement are selected through the monitoring of identified quality and performance indicators.

The Utilization Management, Health Management and Quality Improvement operational functions are under the direct supervision of the Plan Medical Director and Chief Medical Officer, respectively.

Quality Improvement functions in conjunction with the Health Plan Organizational Structure and the Quality Improvement Committee and subcommittee structures to promote appropriate system development and implementation to meet the requirements of Members, employers, employees and the Practitioner/Provider network.

Additional information regarding the Utilization Management and/or the Quality Improvement programs is available by accessing Prominence Health Plans website at www.prominencehealthplan.com or call Customer Service at 775.770.9312 or 800.433.3077.

4. AFFIRMATIVE STATEMENT REGARDING INCENTIVES

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

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

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

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

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

Part V. Eligibility, Enrollment And Effective Date Of Coverage

1. Eligible Employees

a. To be eligible to enroll as a Subscriber You must:

   i. Work the regularly scheduled number of hours for coverage as designated by the Group in the Master Group Application;

   ii. Be an eligible employee of the Group entitled to participate in the healthcare benefit program arranged by the Group or be entitled to coverage under a trust agreement or employment contract; and

   iii. Satisfy any probationary or Waiting Period requirements established by the Group and enroll within 31 days of Your eligibility date.

   iv. Complete a health assessment form and/or provide a certificate of creditable coverage.

b. To be eligible for retiree medical benefits You must:

   i. Be an active Member entitled to benefits under this COC up to the time of Your retirement;

   ii. Meet the eligibility requirements for retiree medical coverage as designated by Your Group in the Master Group Application; and

   iii. If You or Your spouse are eligible for Medicare Parts A & B, You must enroll in Medicare Parts A & B.

c. Eligibility for Dependents of Retirees

   i. To be eligible to enroll as a dependent of a retiree, a retiree must be a Member entitled to retiree medical benefits under this COC.

   ii. A retiree must make the election to cover dependents at the time of retirement - a retiree cannot enroll his or her spouse or child for coverage at a later time.

   iii. A retiree cannot add a new spouse (due to marriage or remarriage) or newly acquired children due to birth or adoption) after the retiree's initial election;

   iv. Dependent children include a retiree's natural children, legally adopted children, children for whom the retiree acts as the legal guardian, stepchildren who are dependent on the retiree for support, and children for whom the retiree acts as the proposed adoptive parent from the date of placement. Dependent children are eligible for PPHIC plan benefits until age 26, unless otherwise covered by other employer provided health plan coverage.

d. Employees who refuse coverage for any reason and later decide they want coverage will not be eligible until the next Group Open Enrollment Period. However, the employee may revoke a coverage election if one of the following qualifying events has occurred and they are adding newly eligible Dependents:

   i. Marriage;

   ii. Death of Spouse;

   iii. Divorce or annulment;

   iv. Legal separation;

   v. Birth;

   vi. Adoption or placement for adoption;

   vii. Death of dependent child;

   viii. Newly eligible dependents due to plan design change;

   ix. Loss of coverage;

   x. Dependent status change;

xi. Employment status change;

xii. Judgment decree or order requiring coverage; and

xiii. Change in residence

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

e. If an employee refuses coverage at the time of enrollment because he had other Qualifying Coverage, he will be eligible to enroll if one of the following has occurred:

i. Employee is no longer eligible for benefits under the other Qualifying Coverage;

ii. Expiration of COBRA continuation coverage;

iii. Termination of employment causing termination from the other Qualifying Coverage;

iv. Reduction of the number of hours of employment, resulting in termination of the other Qualifying Coverage;

v. Employer contributions toward other Qualifying Coverage terminated; or

vi. Death or divorce of a spouse resulting in the termination of the other Qualifying Coverage.

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

2. Eligible Dependents

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

i. Be the Subscriber's legal spouse;

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

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

02. Have not terminated that domestic partnership;

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

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

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

06. Both persons share a common residence; and

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

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

09. A surviving domestic partner, following the death of the other partner, has the same rights, protections and benefits, and is subject to the same responsibilities, obligations and duties under law, whether derived from statutes, administrative regulations, court rules,

government policies, common law or any other provisions or sources of law, as are granted to and imposed upon a widow or a widower.

10. The rights and obligations of domestic partners with respect to a child of either of them are the same as those of spouses. The rights and obligations of former or surviving domestic partners with respect to a child of either of them are the same as those of former or surviving spouses.

iii. Be a married or unmarried child under the age of 26. The term "child" includes natural children, stepchildren, eligible foster children, and children for whom You have been appointed by the courts as permanent legal guardian, or children who have been legally adopted or are awaiting finalization of adoption by You; or

iv. Be an unmarried child who is and continues to be both (1) medically certified as mentally or physically disabled and (2) dependent upon the Subscriber of the insured Group for support and maintenance. This condition must have occurred before the child reaches age 19. Proof of this incapacity must be furnished to PPHIC within 31 days after such Dependent attains age 19 and then once a year beginning two years after the Dependent has reached the age of 19. PPHIC will require a completed Dependent Disability Verification form, provided by PPHIC and evidence that the dependent is declared to be financial dependent on the Subscriber's tax documents.

b. Non-eligible Dependents are defined as persons to include, a child placed in the Subscriber's home (except those placed for adoption), a grandchild of Subscriber or Subscriber's spouse, an emancipated minor (as defined by Nevada law), legal wards (except those legal wards permanently placed in Subscriber's home by court order), and individuals whom You are the authorized power of attorney as appointed by the courts. Parents and/or relatives of the Member or Member's spouse are not considered eligible Dependents.

c. Employees who refuse coverage for their Dependents, for any reason, and later decide they want coverage will not be eligible until the next Group Open Enrollment Period. However, if a Dependent refuses coverage at the time of enrollment because they had other Qualifying Coverage, they will be eligible to enroll if one of the following has occurred:

   i. Dependent is no longer eligible for benefits under the other Qualifying Coverage;

   ii. Expiration of COBRA continuation coverage;

   iii. Termination of employment causing termination from the other Qualifying Coverage;

   iv. Reduction of the number of hours of employment, resulting in termination of the other Qualifying Coverage;

   v. Employer contributions toward other Qualifying Coverage terminated; or

   vi. Death or divorce of a spouse resulting in the termination of the other Qualifying Coverage for Dependent children.

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

d. Newborns of enrolled employees will be covered from the date of birth for 31 days. Coverage after the 31st will be provided only if the newborn is enrolled within 31 days from the date of birth.

e. Adopted or placed Dependents will be covered as of the date the adoption becomes effective or the date the child is placed in the home, whichever occurs first. An enrollment form must be completed and received by PPHIC within 31 days of the event. Certification by the adoption or placement agency will be required.

f. Marriage, remarriage and/or newly acquired Dependents (e.g., stepchildren) will be covered only if an enrollment form is completed and received within 31 days from the date of marriage.

g. Request for birth certificates, marriage license, court orders, or other items (e.g., Certificates of Coverage, US citizenship) must be furnished by the Member to PPHIC within 31 days of receipt of the request. Failure to furnish the requested documents will result in ineligibility Enrollment

3. Enrollment

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

a. Initial Enrollment: As an employee of the Group, You are entitled to apply for coverage for Yourself and Your eligible Dependents during the initial Group Open Enrollment Period. All persons included for coverage must be listed on the provided enrollment form.

b. Group Open Enrollment: A Group Open Enrollment Period shall be held for at least 15 days once every 12 months at which time You or Your eligible dependents may enroll as a Subscriber and/or a Member of PPHIC.

c. Notice of Ineligibility: It is Your responsibility to notify PPHIC of any changes which affect Your eligibility or the eligibility of Your Dependents within 31 days of the event.

d. Limitation: Persons initially or newly eligible for enrollment who do not enroll within 31 days of eligibility may only be enrolled during the next Group Open Enrollment Period, unless a Qualifying Coverage event occurs.

4. Effective Date of Coverage

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

a. Initial Enrollment and Open Enrollment: Coverage shall begin on the date agreed upon by the Group and PPHIC.

b. Newly Eligible Employees: Coverage will become effective on the Group's eligibility date.

c. Newly Eligible Dependents: Coverage will begin as of the date of the event such as marriage, adoption, or guardianship, ONLY if the enrollment form, if applicable, is received within 31 days from the date of the event. Newly eligible Dependents not added within the 31 days may not be added until the next Group Open Enrollment Period, unless a Qualifying Coverage event occurs.

d. The effective date of coverage as noted in a. and b. above, may be changed by agreement of the Group and PPHIC.

e. PPHIC will provide You with a COC and other Member materials upon enrollment.

Part VI. Services And Benefits

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

1. Allergy Care

a. Coverage is provided for allergy testing, evaluation and for the preparation of allergy serum and shots.

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

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

a. Homeopathic treatment, Acupuncture and Integrated Medicine will be covered when medically necessary.

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

c. For coverage limitations, please consult Your SOB.

3. Ambulance Services
Non-emergency

a. Ground ambulance services: medically necessary ambulance services provided within the service area and arranged in advance by an In-Network Practitioner/Provider and Prior Authorized by Prominence HealthFirst for the medical necessity of transporting You from one facility to another facility.

b. Air ambulance services: medically necessary ambulance services provided within the service area only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Must be arranged in advance by an In-Network Practitioner/ Provider and Prior Authorized by Prominence HealthFirst for the medical necessity of transporting You from one facility to another facility.

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

Emergency

d. Ground ambulance services: medically necessary ambulance services provided within the service area when the ambulance is ordered for an emergency that could jeopardize Your health. Ambulance service will be covered when ordered by an employer, school or public safety official, or when You are not in a position to refuse the service. This excludes ambu-lance services for work-related injuries or illness or Non-Covered Services even if determined to be Medically Necessary.

e. Air ambulance services: medically necessary ambulance services for emergency transport is covered to the nearest hospital equipped to treat your condition only when transport by ground ambulance or other means would endanger your life or cause permanent damage to your health. Your symptoms at the time of transport must meet these requirements and must be verified by the records of the physician who treats you and by the ambulance company.

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

4. Clinical Trial or Study:

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

a. Clinical trial or study must be approved by:

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

5. Cochlear Implants & Hearing Aids

a. Prosthetic cochlear implant is covered only for children 12 and under with Congenital postlingual, profound, bilateral deafness who receive limited or no benefit from hearing aids. Benefit is limited to one per Member per lifetime. Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).

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

6. Contraception and Sterilization

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

7. Dental Care Services

Dental Services permitted under the medical plan include:

a. Treatment for accidental dental injury to Sound Natural Teeth, the jawbones, or surrounding tissues.

   This does not include tooth breakage while chewing. Treatment and repair must begin within 6 months of the date of a documented injury and may require Prior Authorization.
b. Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth.
c. Use of an outpatient or inpatient facility for dental procedures/services may be covered using the following criteria.
   i. Anesthesia/Facility Coverage
      01. Coverage is for dependent children less than 18 years of age only.
      02. The Member must have a diagnosed medical or behavioral condition, which requires outpatient hospitalization or general anesthesia when dental care is provided.
      03. Services must be provided by a designated contracted facility and anesthesiologist.
      04. Services rendered by a dentist are not a Covered Service; and
      05. May require Prior Authorization.
   ii. For coverage limitations, please consult Your SOB and Prior Authorization list.
d. Dental examinations, dental implants, bridges, dental prescriptions, orthodontia and any other dental products or services are not covered except when related to accidental inquiry to sound natural teeth.
e. Orthognathic surgery is the surgical correction for congenital malposition of the bones of the jaw; the mandible, maxilla or both. The abnormality may be congenital, developmental or the result of

disease. Orthognathic surgery may be considered Medically Necessary when non-surgical therapies fail and when Prominence Health Plan's Technological Assessment Policy for Orthognathic surgery is met. Prior Authorization may be required and coverage is limited.

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

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

f. Appliance therapy which does not permanently alter tooth position, jaw position or bite relationship. The benefit for appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair and replacement of the appliance. Dental orthotics or appliances including, but are not limited to, oral appliances and night guards. Note: Night guard appliances are not subject to the Temporomandibular Joint Disorder (TMJ) benefit limits.

g. Temporomandibular Joint Disorder (TMJ): Covered services for any jaw joint problem, including TMJ disorder, craniomandibular disorder, head and neck neuromuscular disorder, or other conditions of the joint linking the jaw bone and skull include only medical services. Services or supplies recognized as dental procedures or supplies, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints, are not covered.

i. Medical or surgical services related to TMJ or surgery are covered. Services must be provided by an In-Network Practitioner/Provider.

ii. The following are not Covered Services for TMJ:

01. A single examination including a history, physical examination, muscle testing, range of motion measurements and psychological evaluation, as necessary;

02. Diagnostic x-rays and in some instances second opinions may be required;

03. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is received on the same date of service; and

04. Therapeutic injections.

iii. The following are not Covered Services for TMJ:

01. CT Scans or magnetic resonance imaging (MRI) except in conjunction with surgical management;

02. Electronic diagnostic modalities;

03. Occlusal analysis;

04. Any procedure not specifically listed as a Covered Service.

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

8. Dermatology

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

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

b. Due to its anatomic location, the lesion has been subject to recurrent trauma

c. Lesion appears to be malignant or pre-malignant (e.g. actinic keratoses, Bowen's disease, dysplastic lesions, lentigo maligna, or leukoplakia) or malignant (due to coloration, change in size or appearance, family history or patient history of melanoma)

d. Skin lesions are causing symptoms (e.g. bleeding, burning, itching or irritation)

e. The lesion has evidence of inflammation (e.g. edema, erythema, or purulence)

f. The lesion is infectious (e.g. warts)

g. The lesion restricts vision or obstructs a body orifice.

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

9. Diabetic Supplies and Services

a. Coverage is provided for insulin and insulin syringes, diabetic blood or urine test strips and lancets. Each item requires a separate prescription and is limited to one month supply. A Copayment applies per 100 strips. This benefit must be coordinated by a Medical Plan Practitioner/Provider and obtained from a Plan Pharmacy. Services also include training and education.

b. Routine foot care.

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

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

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

10. Durable Medical Equipment

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

a. Coverage is provided for DME as prescribed and must be coordinated by an In-Network Practitioner/Provider and may require Prior Authorization by PPHIC.

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

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

d. Lymphedema Treatment: No more than 2 pair of pneumatic compression garments are covered per calendar year.

e. Compression stockings: No more than 4 pair of individually fitted prescription graded compression stockings with more than 18 mm Hg are covered per calendar year.

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

11. Eating Disorders

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

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

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

b. Medical Nutrition Therapy Counseling

   i. Coverage is provided for Medically Necessary Medical Nutrition Therapy/Nutritional Counseling, with PCP/Practitioner for the following conditions: Diabetes, Obesity (BMI greater than 40 or BMI less than 35 with co-morbidities), Renal failure, GI Disorders and Eating Disorders.

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

12. Emergency Care Services

Under the Affordable Care Act (ACA), PPHIC is not permitted to charge higher copayments or co-

insurance for Out-of-Network emergency room services, or require approval before seeking emergency room services from a provider or hospital outside the provider network. Grandfathered individual health insurance policies are not required to follow these rules.

The PPHIC Emergency Services are provided as follows:

a. A Prior Authorization may be required, even for out-of-network services;

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

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

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

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

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

i. Serious jeopardy to the health of a Member;
ii. Serious jeopardy to the health of an unborn child;
iii. Serious impairment of a bodily function; or
iv. Serious dysfunction of any bodily organ or part.

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

Emergency Care Services does not include instances when You are seen in a contracted emergency room for a condition that was not Medically Necessary and that PPHIC determines did not require Emergency Services, or; follow-up care obtained through an emergency room.

13. Genetic Breast Cancer (BRCA) Testing

The following services may require a Prior Authorization from PPHIC:

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

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

c. Genetic testing will be covered in connection with pregnancy management in the following circumstances

   i. Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

   ii. Parents of a child with mental retardation, autism, down syndrome, trisomy conditions, or fragile X syndrome;

   iii. Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects;

iv. Parents affected with an autosomal dominant disorder, contemplating pregnancy;

v. Mother is a known or presumed carrier of an X-linked recessive disorder.

d. Genetic testing unrelated to pregnancy is covered in conjunction with covered genetic tests and in accordance with the guidelines of the American College of Medical Genetics (ACMG)

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

14. Health and Wellness Services

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

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

15. Hemophilia Services

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

16. Home Health Services

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

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

17. Hospice Care

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

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

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

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

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

18. Hospital Services

a. Inpatient Services: Coverage is provided for the following Medically Necessary Covered Services and may require Prior Authorization by PPHIC. It is the Member's responsibility to notify Prominence Preferred Health Insurance Company of an inpatient hospital admission within 48 hours or the next business day; failure to notify Prominence Preferred Health Insurance Company will result in a financial penalty.

i. Semi-private room and board, with no limit to number of days except as described in Your SOB for Mental Health Inpatient Services.

ii. Inpatient In-Network Practitioner/Provider Services.

iii. Private rooms are covered only when Medically Necessary and must be Prior Authorized by PPHIC.

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

v. Drugs, medications, biologics and their administration.

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

vii. Anesthesia and oxygen services.

viii. Physical therapy and other rehabilitation services required as part of a Medically Necessary Hospital stay. Coverage is limited to Covered Services which are anticipated to result in significant clinical improvement within a reasonable period of time.

ix. Radiation therapy, infusion therapy and dialysis.

x. Blood and blood plasma products and their administration.

xi. Cardiac Rehabilitation Program Phase I.

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

i. Radiation therapy, chemotherapy, infusion therapy and dialysis.

ii. Short-Term Rehabilitative Services are limited to treatment of conditions which are subject to significant clinical improvement over a 3 month (90 day) period from the date inpatient or outpatient therapy commences for post surgical conditions and over a 2-month (60-day) period from the date inpatient or outpatient therapy commences for all other conditions, and in the judgment of the PPHIC Medical Director is subject to significant clinical improvement.

iii. Outpatient surgery and diagnostic procedures.

iv. Cardiac Rehabilitation Program Phase II.

v. When Your outpatient status changes to inpatient, You will be responsible for an inpatient Deductible/Coinsurance.

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

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

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

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

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

19. Infertility Testing and Services

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

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

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

ii. Laboratory studies;

iii. Diagnostic procedures; and

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

b. Specific Exclusions

The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by PPHIC not to be Medically Necessary;

i. 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;

ii. Home pregnancy or ovulation tests;

iii. Monitoring of ovarian response to stimulants;

iv. Sterilization reversal;

v. Laparoscopy;

vi. Ovarian wedge resection;

vii. Removal of fibroids, uterine septae and polyps;

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

ix. Surgical lysis of adhesions;

x. Surgical tube reconstruction.

20. Kidney Dialysis Services

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

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

21. Laboratory and Pathology Services

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

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

22. Maternity and Newborn Care

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

i. Prenatal and Postpartum care including any and all complications of pregnancy.

ii. Amniocentesis when performed in the last trimester for the purpose of determining fetal lung maturity, in the first 16 weeks for genetic testing or the need for fetal therapy.

iii. Use of Hospital delivery room and related facilities may require Prior Authorization by PPHIC.

iv. Use of Newborn nursery and related facilities.

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

23. Mental Health Services and Substance Abuse Benefit

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

a. Alcohol and Drug Addiction or Abuse Services Benefit Description

i. Withdrawal Treatment: Coverage is provided for Medically Necessary Covered Services relating to the physiological effects of alcohol or drugs on either an inpatient or outpatient basis when coordinated by an In-Network Practitioner/Provider.

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

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

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

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

b. Mental Health Disorders Benefit Description

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

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

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

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

c. For coverage limitations, please consult Your SOB.

24. Morbid Obesity

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

i. The Member must have either:

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

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

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

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

003. Must be at least 18 years of age.

004. Cardiovascular risk factors included but are not limited to, history of cigarette smoking, hypertension, high LDL-cholesterol serum levels, low HDL-cholesterol serum levels, impaired fasting glucose, family history of premature CHD.

ii. There is adequate documentation that the Member has failed less invasive methods of weight loss and is at high risk for obesity-associated morbidity or mortality. Less invasive therapies include low-calorie dieting, increased physical activity, behavioral therapy and pharmacotherapy, where appropriate.

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

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

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

iv. If Member is diabetic, disease is controlled;

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

vi. Procedure must be performed at an In-Network Facility unless approved by PPHIC to be performed at an Out-of-Network Facility/Provider; and

vii. Member must be tobacco-free for (8) eight weeks prior to surgery.

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

25. Nutritional Supplements, Enteral Therapy and Parenteral Nutrition

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

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

c. As used in this section:

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

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

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

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

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

26. Organ Transplant Services

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

a. Transplants to a Member are limited to heart, kidney, cornea, liver, lung, tendons, sclera, and allogenic and autologous bone marrow only.

b. Coverage is provided for the Medically Necessary Hospital, surgical, laboratory, and x-ray expenses incurred by a donor for an Authorized transplant to a Member, unless the donor has coverage for such expenses. Donor care is limited to 60 days following the transplant procedure. Donor care following the transplant procedure is limited to services and supplies related to the transplant only.

c. There is no coverage for a Member acting as a transplant donor to a non-PPHIC Member.

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

e. Procedures must be performed at a PPHIC Transplant network facility.

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

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

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

27. Plastic and Reconstructive Surgery

When Medically Necessary, the following Covered Services may require Prior Authorization by PPHIC:

a. Reconstructive surgery incidental to or following surgery resulting from acute trauma, infection, or other diseases of the involved body part while insured with PPHIC.

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

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

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

28. Prescription Drug Benefit

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

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

ii. Out-of-Network Pharmacy: a pharmacy not contracted with PPHIC as a Plan Pharmacy.

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

b. Formulary: Prescription drug coverage requires Members to use the PPHIC Formulary. This list of medications is created and maintained by the PPHIC Pharmacy and Therapeutics Committee, based upon current medical standards of practice. Some medications on the Formulary may require Prior Authorization and/or have a limited benefit. Approved U.S. Food and Drug Administration (FDA) female oral contraceptive generic drugs are listed in the Formulary. If You wish to receive a copy of the PPHIC Formulary, please contact the Customer Service Department at 775.770.9312 or 800.863.7515.

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

- FDA-approved indications
- Efficacy
- Adverse effect profile
- Patient monitoring requirements

- Impact on total healthcare costs
- Comparison to other preferred agents

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

d. Generic Drugs, Preferred Brand Drugs and Non-Preferred Brand Drugs, require payment of the prescribed copayment as listed in the PPHIC SOB document. Member must pay the copayment to the Plan Pharmacy at the time the Prescription is filled, for each prescription or refill dispensed, up to a 30-day supply.

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

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

    iii. Non-Preferred Brand Drug: A Name Brand Drug which often has a Generic equivalent.

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

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

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

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

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

j. The prescription drug benefit includes coverage for early refills of topical ophthalmic products due to inadvertent wastage.

k. The prescription drug benefit includes coverage for synchronized medication packs dispensed by a pharmacy.

l. **Prescription Drug Benefit Exclusions**

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

    ii. Dietary Aids and Appetite Suppressants: dietary or nutritional products, including prescription or non-prescription vitamins (except those prescribed pre-natal vitamins listed on the PPHIC Formulary), appetite suppressants, and diet pills used for weight reduction, except as otherwise permitted in the Certificate of Coverage and SOB documents.

    iii. Experimental or Investigational: drugs labeled "Caution: Limited by Federal Law to

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

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

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

vi. Nail Fungal Medications and/or Preparations.

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

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

ix. Over-the-Counter Drugs: over-the-counter drugs and other items which do not require a written prescription (even if ordered by a PPHIC plan practitioner).

29. Preventive Services

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

b. Periodic Gynecological examination and cytological screening for females as recommended by Your Primary Care Physician or as per recommendations from the U.S Preventive Services Task Force.

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

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

e. Well-child visits and annual physicals as recommended by Your Primary Care Physician or as per recommendations from the U.S Preventive Services Task Force.

f. Vision and hearing screening examinations for ages 19 and under to determine the need for vision and hearing correction as recommended by Your Primary Care Physician or as per recommendations from the U.S Preventive Services Task Force Screening does not include determination of refractive state. Frames and lenses for the care of Strabismus (cross-eyed) are limited to one pair per calendar year.

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

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

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

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

k. Women's Preventive Services

i. FDA-approved contraceptive products.

ii. Domestic and interpersonal violence screening and counseling.

iii. Well-woman visits.

iv. BRCA genetic counseling and testing services.

v. Gestational diabetes screening.

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

vii. Sexually transmitted infections (STI) counseling.

viii. HIV Screening and Counseling

ix. Breastfeeding support, supplies, and counseling.

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

xi. For more information visit the U.S Preventive Services Task Force: www.hrsa.gov/womensguidelines

30. Professional Services

a. In-Network Practitioner/Provider Office Visits: Medically Necessary Covered Services are provided for the diagnosis and treatment of illness or injury when provided in the medical office of an In-Network Practitioner/Provider.

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

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

31. Prosthetic and Orthotic Devices

a. Prosthetic devices which aid body functioning or which replace a limb or body part after accidental or surgical loss to correct a defect of body form and function as defined by Medicare DME guidelines are a covered service. Benefits are provided only for the basic Prosthetic.

Prosthetic devices are limited to artificial limbs and eyes and orthopedic braces and supports which are custom-made for You. Specifically not covered are: special shoes, insoles, corsets, trusses and all other such devices. The maximum benefit may be applied to computer-aided Prosthetic devices.

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

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

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

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

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

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

32. Radiology and Diagnostic Services

a. Coverage is provided for Medically Necessary prescribed radiological and diagnostic services when required to diagnose or monitor a symptom, disease or condition. Services include, but are not limited to, routine radiology and ultrasound and, diagnostic testing and complex diagnostic testing when coordinated by an In-Network Practitioner/ Provider.

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

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

33. Spinal Manipulation

a. Spinal manipulation covers treatment of acute back, shoulder and neck conditions when they interfere with normal functions.

b. Spinal manipulation for Chronic/Supportive conditions, maintenance, and/or preventive therapy is not a Covered Service (see definition for Chronic/Supportive).

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

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

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

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

34. Telemedicine

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

35. Therapies (Physical, Occupational, Speech, Autism, Rehabilitative and Habilitative)

a. Speech, physical, developmental and occupational therapy are provided on a Short Term outpatient basis and must be coordinated by an In-Network Practitioner/Provider. Outpatient Short Term Rehabilitation Services are limited to treatment of conditions the PPHIC Medical Director determines to result in significant clinical improvement. These therapies are limited to 60 visits per condition, per Member per calendar year.

b. Habilitative Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. These therapies are limited to 60 visits per condition, per Member per calendar year.

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

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

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

   - Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
   - Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.
   - The Maximum number of therapy treatments per Member is limited to 375 services per year.

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

36. Urgent Care Services

a. Urgent/Ambulatory Care Services

All benefits included in this COC are designed to be available for Medically Necessary Covered Services, which are provided in the most appropriate care setting. Urgent/Ambulatory Care Services are defined as care for an injury, illness or another type of condition which should be treated within 24 hours.

When You are seen in an Urgent/Ambulatory Care facility for a condition not Medically Necessary and that PPHIC determines did not require urgent/ambulatory services, or fail to follow the proper procedures as defined above, You will be held financially responsible for all charges related to this visit.

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

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

a. Coverage is provided for vision examination (refraction), when provided by a duly licensed Vision Care Provider, to determine the presence of vision problems or other abnormalities. Refraction exams are limited to one per Member per Calendar year for individuals age 19 and under.

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

i. Frames and/or Prescribed Corrective Lenses:

01. This benefit is limited to one pair of basic glasses (Frames and Prescribed Corrective Lenses) per Member per Calendar Year.

ii. Prescribed Corrective Contact Lenses:

01. Prescribed corrective contact lenses are limited to one pair per Member per Calendar Year. Six (6) pairs of Contact Lenses can be substituted in lieu of glasses.

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

01. upon proof of payment by Member; or

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

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

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

a. All stages of reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

c. Prosthesis and treatment of physical complications of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;

d. Treatment of physical complications of all stages of mastectomy, including lymphedemas;

e. Such coverage may be subject to the same annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under this plan.

Part VII. Exclusions, Limitations And Non-Covered Services

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

1. **Bariatric services -** Any reconstructive and/or cosmetic procedure following Bariatric Restrictive Surgery and/or excessive weight loss to remove excess skin on any part of the body, procedures including but not limited to, lifts, tucks, abdominoplasty, and body contouring, regardless of medical necessity Surgical or invasive treatment, or reversal thereof, for reduction of weight regardless of associated medical or psychological conditions, except as otherwise permitted in this COC.
2. **Chelation treatment -** Chelation Therapy, except for recognized or standard medical care to treat heavy metal poisoning.
3. **Complication of non-covered service -** Complications resulting from excluded a) cosmetic treatment or b) erroneous medical/surgical procedures.
4. **Convenience items and services -** Personal comfort, convenience and duplicate items, services, supplies or equipment, including exercise equipment which is primarily for the Member's education, training or development of skills needed to cope with an injury, sickness or condition. Supplies and consumables including, but not limited to, dressing, any equipment to condition the air, appliances, ambulatory apparatus, heating pads, personal care or beautification items, deluxe equipment, wheel chair lifts, four-channel muscle stimulators and any other primarily non-medical equipment. Special equipment and devices used for sports.
5. **Compression stockings -** Compression stockings with a pressure gradient of less than 18mm Hg including but not limited to, elastic stockings, surgical leggings, anti-embolism stockings (Ted Hose) or pressure leotards.
6. **Cosmetic services -** Cosmetic surgery or treatment defined as any plastic or reconstructive surgery or procedure done primarily to improve the appearance of any portion of the body in the absence of specific functional limitations from which no substantial clinical improvement in physiologic function could be reasonably expected. Cosmetic Exclusions include, but are not limited to, the following:
   a. Abdominoplasty, regardless of medical necessity
   b. Surgery for sagging or extra skin; to include thigh, leg, hip, buttock, arm, forearm and hand, regardless of Medical Necessity;
   c. Face lifts, brow lifts and rhinoplasty, regardless of Medical Necessity;
   d. Laser, LASIK (laser-assisted in situ keratomileusis), radial keratotomy and any other surgical procedure to alter Refraction;
   e. Any augmentation or reduction procedures or correction of facial or breast asymmetry. Breast augmentation, lifts or reductions which are not associated with cancer of the breast, regardless of Medical Necessity; or any removal of breast implants or breast reconstruction which is not associated with breast cancer. Breast reductions and removal of ruptured breast implants (not replacements unless related to a prior mastectomy) may be covered when prior authorized and medically necessary.
   f. Hair removal or treatment of baldness;
   g. Scar revision therapy and laser services for scars;
   h. Any implant, appliances or devices used to improve the appearance and/or function of a portion of the body, regardless of Medical Necessity;
   i. Earring injuries and/or earlobe repairs;
   j. All body piercings;
   k. Treatment for melasma, hyperpigmentation, hypopigmentation, port wine stain, birth marks,

chemical peels and laser treatment of acne, surgical treatment of rosacea, telangiectasia and spider veins, benign lesions and skin disorders, including lipomas but not limited to, hemangiomas and seborrheic keratosis, regardless of Medical Necessity.

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

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

8. **Dental -** Dental care including but not limited to, treatment of the teeth, extraction of teeth (including wisdom teeth), dental surgery and/or oral surgery, treatment of dental abscesses, treatment of gingival tissues (other than tumors), dental examinations, dental implants, bridges, dental prescriptions, orthodontia and any other dental products or services.

a. Treatment or replacement of any tooth or any supporting tooth structure, alveolar process or disease of the periodontal or gingival tissue;

b. Surgery or splinting to adjust dental occlusion;

c. Treatment of jaw disorders;

d. Maxillary or mandibular surgery;

e. Any irreversible procedure including, but not limited to, orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures.

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

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

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

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

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

14. **Experimental/investigational -** Any services that in PPHIC's sole discretion is determined to be experimental or investigational medical, surgical or other procedure or treatment, including prescription medications – unless otherwise directed by State Federal regulations. A procedure or treatment is considered experimental:

a. If there is insignificant outcomes data available from controlled clinical trials and from medical literature to show that the procedure or treatment is safe and effective;

b. If the procedure or treatment has not been deemed consistent accepted medical practice with standards established by the National Institutes of Health, the Food and Drug Administration, or the Medicare program;

c. If it is determined that the procedure or treatment is not generally accepted by the medical community within the State of Nevada;
d. When a nationally recognized medical society states in writing that the procedure or treatment is experimental;
e. When the written protocols used by a facility studying the procedure or treatment state that it is experimental; or
f. When the treatment or service requires approval by any governmental authority prior to use and such approval has not been granted when the treatment or service is to be rendered.

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

16. Infertility treatment/services - Embryonic transfer, Gamete intra-fallopian transfer (GIFT), in vitro fertilization and sperm donation (including storage of) or any related services for treatment of infertility. Additional Exclusions include, but are not limited to, the following:

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

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

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

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

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

delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

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

21. **Maternity -** Childbirth outside of the Service Area if the Member has entered her third trimester of pregnancy, unless travel was supported by a Practitioner recommendation. Unless otherwise excluded please refer to the section entitled "Maternity and Newborn Care."

    Amniocentesis, except as otherwise permitted in this COC. Collection and banking of cord blood is not covered. Doulas are specifically excluded.

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

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

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

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

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

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

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

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

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

    a. The Member's spouse.

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

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

Member of the Insured Person's household.

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

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

26. Pharmacy/drugs - Costs related to the acquisition or use of medical marijuana.

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

Self-injectables except for diabetic medications and supplies.

27. Residential Treatment - Residential Treatment, except that which is provided by an accredited facility.

28. Saliva Testing - Costs related to saliva testing.

29. Sex change services - Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite gender including, but not limited to, any treatment, medications or studies related to gender transformation. The exclusion does not apply to medically necessary services when prior authorization is submitted and approved by Utilization Management.

30. Sexual dysfunction - Penile implants and any related sexual devices, appliances, services or medications for sexual dysfunction.

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

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

33. Third opinions - Opinions and consultations beyond the second opinion.

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

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

36. Urgent Care Services - Urgent Care Services obtained inside the Service Area by a Non-Plan Urgent Care Facility.

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

Ophthalmological/Vision services provided in connection with the testing of visual acuity or determination of refraction error for the fitting of eyeglasses or contact lenses. The furnishing or replacing of eyeglasses or contact lenses will not be a benefit, except when following cataract surgery

including eye exercise therapy. These exclusions only pertain to adult vision services.

The following items are specifically excluded under this benefit:

a. Safety glasses required for employment
b. Non-prescription glasses and contact lenses
c. Tinted contact lenses not used for corrective purposes
d. Glass lenses for Members through age 19
e. Non-prescription sports related protective eye wear

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

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

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

Part VIII. Plan Administration

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

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

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

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

5. For the initial claim, PPHIC reserves to itself and its designated administrators the right to interpret or construe the terms of this COC, to resolve all questions concerning the status and rights of Subscribers and others under the COC, including, but not limited to, eligibility for benefits, and to make any other determinations it deems reasonable in the administration of the COC, the right to revise this COC in accordance with state regulatory agencies. This provision does not restrict the ability of a Member to dispute any claim decision including the right to file a complaint with the Nevada Division of Insurance, or the U.S. Department of Labor, or Nevada Consumer Health Services, or the U.S. Department of Health and Human Services, Appeal an Adverse Benefit Determination, to have it reviewed externally (when appropriate) or to demand mediation and/or arbitration or to file a lawsuit. See Part XIII, "Notice of Privacy Practices," Part XVII, "Internal Claims and Appeal Procedures," Part XIV, "Mediation and Arbitration Agreement," and Part XX, "Specific Authorization Agreeing to Mandatory Mediation and Arbitration Provisions."

6. The Member ID card is issued by PPHIC pursuant to this COC for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this COC and misuses of such Identification card constitutes grounds for termination of coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this COC, the holder of the card must be a Member on whose behalf all applicable Premium charges under this COC have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this COC shall be charged for such services or benefits at prevailing rates.

7. You are entitled to ask if PPHIC has special financial arrangements with their contracted Provider/Practitioner that may affect Referral services, such as laboratory tests and hospitalizations that You might need. Information is available upon request, to current, previous and potential plan Members regarding whether PPHIC contracts include Practitioner/Provider incentive plans that affect the use of referral services.

8. Transfer of Medical Benefits from Prior Plan.
    a. When this COC replaces another policy, and employee or his Dependents were covered on the

date the prior policy ended, insurance will become effective under this COC on the original date of issue even though:

i. Employee may not be actively at work; or

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

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

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

i. The date You or Your Dependents are eligible under the other provisions of this COC;

ii. The date coverage terminates under this COC.

Part IX. Termination Of Coverage

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

Part X. Continuation Of Coverage

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

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

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

   a. You have been discharged as an inpatient;

   b. The maximum benefit period is reached;

   c. Your employment with the Group is terminated;

   d. The Group subsequently replaces PPHIC coverage with other Group coverage for which You are eligible; or

   e. A period of twelve (12) months from the date of termination has elapsed.

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

   a. The date on which Your employment is terminated;

   b. The date on which You obtain another policy of health insurance;

   c. The date on which the policy of group health insurance is terminated; or

   d. After a period of twelve (12) months in which benefits under this COC are provided to You.

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

   Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) You may be eligible for continuation of coverage under this COC. This is provided that Your Group employs 20 or more persons, You have a qualifying event, and You elect to continue coverage within 60 days of the qualifying event. Qualifying events include:

   For Employees

   a. voluntary or involuntary termination of employment for reasons other than gross misconduct;

   b. reduction in the number of hours worked resulting in a loss of health plan coverage.

   For Spouses

   a. loss of coverage by the employee because of one of the qualifying events listed above;

   b. covered employee becomes eligible for Medicare;

   c. divorce or legal separation of the covered employee;

   d. death of the covered employee.

   For Dependent Children

   a. loss of coverage because of any of the qualifying events listed for spouses;

   b. loss of status as a dependent child under the rules of the COC.

Each person who is eligible for COBRA continuation coverage can make his or her own decision. If Your dependents were covered under the Plan, they may independently elect COBRA continuation coverage. Continuation coverage will be for the benefits described in this COC and will be at the premium rate specified in the Group contract, plus 2% for administration of the continuation. Under no circumstances shall the Premium exceed 102% of the specific Group Premium rate.

Continuation of coverage will end on the earliest of the following dates:

a. 18 months from the date continuation began as a result of employment termination or reduction in hours;
b. 29 months from the date continuation began as a result of total disability as determined under the Social Securities Act;
c. 29 months from the date continuation began as a result of total disability as determined under the Social Securities Act. If the disability occurred during the first 60 days following the date continuation began;
d. In the case of Dependents, 36 months from the date continuation began as a result of the death of the Subscriber, divorce or legal separation from Subscriber, loss of Dependent status, or Subscriber's entitlement to Medicare;
e. 36 months from the date of the original qualifying event if a second qualifying event occurs;
f. The end of the period in which Premiums have not been paid if the Member fails to make Premium payments as specified by the Group;
g. The date the Member becomes covered under any other employer-sponsored Group health plan;
h. The date the Member becomes entitled to Medicare; or
i. The date the Group contract ends.

4. **Subrogation:** If You or a covered family Member (hereafter collectively "Your") are sick or injured as a result of the act or omission of another person, PPHIC (also referred to as "the Medical Plan") will conditionally advance payment of Medical Plan benefits for Your injury or illness. The purpose of the Medical Plan is to provide coverage for qualified expenses that are not covered by a third party.

If the Medical Plan pays benefits for any claim You incur as a result of negligence, willful misconduct, or other actions of a third party, the Medical Plan will be subrogated to all Your rights of recovery. You will be required to reimburse the Medical Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, Your own insurance company as a result of judgment, settlement, or otherwise. In addition, You will be required to assist the administrator of the Medical Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Medical Plan.

Subrogation means the Medical Plan has the right to recover Medical Plan benefit payments advanced on Your behalf, for an injury or illness caused by another person, and recovered by You or Your dependent from the person who caused You harm (or any insurer acting in place of, or on behalf of that person or any third party's insurer). Third party means any other person or organization.

When You or a covered family Member accept payment of Medical Plan benefits for an injury or illness caused, in whole or in part, by a third party (hereinafter referred to as a "Third-Party Injury") You and Your covered family Members agree the Medical Plan has the right to bring an action for an equitable lien for 100% of the Medical Plan benefits paid on Your behalf from all recoveries You receive from a third party or third party insurer (whether by lawsuit, settlement, or otherwise) in connection with the Third-Party Injury. If Your recovery or Your covered family Member's recovery from the third party is less than the amount of benefits the Medical Plan has paid on Your behalf or on behalf of a covered family Member, You and Your covered family Members agree the Medical Plan has a lien on 100% of the amounts recovered.

This lien shall remain in effect until the Plan is repaid. You and Your covered family Member agree to pay to the Plan the Plan benefits paid on Your or Your covered family Member's behalf out of any

recovery made from another party or insurer. The Plan's right to an equitable lien or a constructive trust shall be given priority over any funds paid by a third party to You or Your covered family Member concerning the injury or sickness, including a priority over any claim for non-medical or dental charges, attorneys' fees, or other costs and expenses.

When You accept payment of medical expenses (i.e. benefits) for an injury or illness caused or contributed to by a third party You agree to the following:

a. Once You have received a recovery of any kind, including a Third-Party Injury recovery, You agree to reimburse Medical Plan for 100% of the benefits paid on Your behalf from all amounts You receive from a third party or third party insurer (whether by lawsuit, settlement, or otherwise) in connection with the Third-Party Injury.
b. If Your recovery is less than the amount of benefits Medical Plan has paid on Your behalf, You agree to reimburse the Medical Plan 100% of the amounts recovered by You.
c. If You make any request or demand for payment to a third party (whether formal or informal) in connection with a Third-Party Injury, You will notify Medical Plan in writing within five (5) business days of making that request. You will also notify Medical Plan in writing within five (5) business days of receiving any payment in connection with a Third-Party Injury.
d. Within five (5) business days of Your receipt of any payment in connection with a Third-Party Injury, You shall deposit 100% of the amounts recovered by You into a bank account. Amounts owed to Medical Plan under this Agreement shall be held in constructive trust for Medical Plan and shall remain in the bank account until paid to Medical Plan pursuant to this Agreement. Medical Plan shall have the right of equitable restitution for any medical benefits paid or provided to You.
e. If You fail to bring legal action to recover payment of health care expenses incurred in connection with a Third-Party Injury, Medical Plan may institute a lawsuit in its own name or in Your name. Medical Plan shall receive an assignment from You of Your rights to recover with respect to any Third-Party Injury. Medical Plan shall be entitled to retain from any resulting judgment or settlement the amount of benefits paid or provided by Medical Plan to You, together with all court costs and attorneys' fees incurred by Medical Plan.
f. You agree to take all reasonable measures to help Medical Plan recover benefits paid or incurred on Your behalf in connection with a Third-Party Injury. You shall execute and deliver any and all such instruments and papers as may be required (including, but not limited to, executing an assignment of Your claims in favor of Medical Plan and will do whatever else is needed to secure Medical Plan's rights under this Agreement. If You do not comply with this Agreement, You will be responsible for the medical benefits paid by Medical Plan and any legal expenses incurred by Medical Plan to enforce its subrogation rights under this Agreement.
g. The Medical Plan's right to recover benefits paid on Your behalf will not be reduced by the "common fund" doctrine or any other equitable defenses nor will it be reduced or made contingent upon You being made whole for the Third-Party Injury.
h. The Medical Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Member or the covered family Member identifies the medical benefits the Medical Plan provided. The Medical Plan is entitled to recover from any and all settlements or judgments. Any recovery will be deemed as compensation for medical expenses, even those designated as "pain and suffering" or "non-economic damages."
i. In the event any claim is made that any part of this Subrogation and Reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Member and the Medical Plan agree that the Medical Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Part XI. Coordination Of Benefits, Third Party Payments And Double Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Definitions:

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

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

03. ESRD - End Stage Renal Disease.

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

ii. Effect on Benefits:

If, according to the rules for determining benefits:

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

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

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

002. Then, PPHIC benefits are paid.

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

b. Rules for determining order of benefits:

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

01. The Member is age 65 or older;

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

03. The Member is actively employed by an Age Discrimination in Employment Act (ADEA) Employer and has more than 20 employees, which pays all or part of the Premium.

The Member is not actively employed by an ADEA Employer, which pays all or part of the Premium, and when the Member is entitled to Medicare Parts A and B, because of age, this PPHIC Plan has secondary responsibility.

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

i. The spouse is age 65 or older;

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

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

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

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

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

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

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

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

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

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

g. **Beginning of Coordination Periods:**

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

      01. The first month of dialysis; or

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

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

h. **End of Coordination Periods:**

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

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

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

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

   iii. The coordination period ends with the earlier of the end of the 18th month of eligibility for

or entitlement to Medicare Part A, for individuals who become entitled to, or eligible for Medicare Part solely on the basis of ESRD from February 1990 through July 1994.

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

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

Part XII. Member Rights and Responsibilities

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

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

3. **Internal Claim and Appeal Procedure:** You have the right to voice complaints or appeals about the organization or the care it provides. You have the right to express Your concerns and problems regarding Your PPHIC overage and benefits. You are encouraged to contact Customer Service at 775.770.9312 or 800.433.3077 with any questions or problems as soon as they arise. PPHIC is committed to providing prompt and responsive service to all Members.

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

4. **Notice of Claim:** You should not have to make payments for Medically Necessary Covered Services to PPHIC In-Network Practitioners/Providers except for the required Copayments, Calendar Year Deductible, or Co-Insurance. If, however, You have paid for services which are covered by this COC, You may be reimbursed providing:

   a. You provide PPHIC with satisfactory evidence that You have properly made such a payment.

   b. You make the request for reimbursement within 12 months of the date of service and provide proof of payment. Requests should be submitted to:

   PPHIC Health Insurance Company, Inc.
   Claims Department
   1510 Meadow Wood Lane
   Reno, Nevada 89502

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

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

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

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

9. **Information:** You have the right to receive information about the organization, its services, Practitioners, Providers and the above rights and responsibilities. To obtain information about Practitioners and Providers who participate with PPHIC, You can call Customer Service at 775.770.9312 or 800.433.3077 or find this information at www.prominencehealthplan.com. You have the right to make recommendations regarding the organization's Member Rights and Responsibilities policies. The Member has the responsibility to provide, to the extent possible, information that PPHIC and its Practitioners/Providers need in order to care for them.

10. **State of Nevada Division of Insurance**
    Carson City Office:
    Phone: 775.687.0700
    Fax: 775.687.0787
    Consumer Compliance & Licensing
    Fax: 775.687.0797
    1818 E. College Pkwy., Suite 103
    Carson City, Nevada 89706

    Las Vegas Office:
    Phone: 702.486.4009
    Fax: 702.486.4007
    2501 East Sahara Ave., Suite 302
    Las Vegas, Nevada 89104
    Division of Insurance Toll Free: 888.872.3234

Part XIII. Internal Claims and Appeal Procedures

The following Member Complaint and Appeal Procedure has been developed to assure a timely and appropriate response to a Member's concerns. Additionally, PPHIC will take into account the clinical urgency of the situation as it relates to the timeliness of responding to Complaints and Appeals. The PPHIC Customer Service Department is available between 8 a.m. and 5 p.m. Monday through Friday at 775.770.9312 or 800.433.3077 to assist the Member.

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

1. **Definitions**

   An Adverse Benefit Determination eligible for "internal" claims and appeals processes includes, but is not limited to a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on, among other things:

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

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

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

2. **Types of Claims**

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

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

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

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

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

   a. **Prior Authorization (Pre-Service) Claims**

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

      If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and You (or Your authorized representative) will have 45 days to provide the specified information to PPHIC after receiving the notice. If all of the needed information is received within the 45-day time frame, PPHIC will notify You of the decision within 15

days after the information is received.

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

3. **Post-Service Claims**

Post-Service claims are those claims with respect to which approval prior to receiving medical care is not required or that are filed after medical care has been received. If Your Post-Service claim is denied, You (or Your authorized representative) will receive a notice from PPHIC within 30 calendar days after PPHIC receives the claim.

4. **Concurrent Care Claims**

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

5. **Urgent Care Claims**

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a physician with knowledge of Your health condition, would subject You to severe pain that cannot be adequately managed without the requested services or in the case of a pregnant woman, cause serious jeopardy to the health of the fetus(es). PPHIC in consultation with Your treating physician, will decide if the claim is an Urgent Care claim. PPHIC will notify You (or Your authorized representative) of the claim decision as soon as practicable, but no later than 72 hours after receiving the Urgent Care claim. However, if necessary information is missing from the claim, PPHIC will notify You (or Your authorized representative) after receiving the claim to specify what information is needed. Determinations of Urgent Care claims may be provided orally, followed within three calendar days by written or electronic notification.

6. **How to File a Claim.**

In order to file a claim, a Member must:

a. Either download a copy of the claim form from our website: http://www.prominencehealthplan.com or request a claim form from the Subscriber's employer or from PPHIC within 20 days after charges are incurred, or as soon as reasonably possible. PPHIC will send the claim form to the Member within 15 days after receiving the request. PPHIC will have the right, at its own expense, to physically examine any Member whose illness or injury is the basis of a claim. This may occur when and as often as PPHIC may reasonably require.

7. **Where to Send a Claim**

Send completed claim forms and the original bills to:

PPHIC Health Insurance Company, Inc.,
1510 Meadow Wood Lane
Reno, Nevada 89502
Telephone: 775.770.9312 / 800.433.3077
Hours of Operation: 8 a.m. - 5 p.m.
Monday - Friday

8. **Payment of Claim**

All benefits will be paid to the Member, or with written direction to the provider of medical services. Any payment made under this option will completely discharge PPHIC from any further obligation. PPHIC

preserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the Member and to any assignees. Such actions will be binding on the Member and on his assignees.

9. When a Claim is Denied

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

i. A notice of Adverse Benefit Determination will include information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), and a statement notifying the claimant that they may request their diagnosis and treatment code(s) as well as the code's corresponding meaning(s). PPHIC will provide such codes and corresponding meanings as soon as practicable after receipt such requests. Requests for diagnosis and treatment code(s) and corresponding meaning(s) are merely information requests and will not trigger the start of an internal appeal or external review;

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

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

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

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

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

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

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

Para obtener asistencia en Español, llame al: 775.770.9312 / 800.433.3077. Los avisos están también dis ponibles en Español a petición.

10. Resolving Complaints

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

11. Internal Appeals of Denied Claims.

a. **Appealing a Denied Claim for Plan Benefits**

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

i. **How to File An Appeal:** To initiate an Appeal, You (or Your authorized representative) must submit a request for an Appeal in writing to PPHIC within 180 calendar days after receipt of Your denial notice. Send completed written appeals to: Prominence Preferred Health Insurance Company, Inc., 1510 Meadow Wood Lane, Reno, Nevada 89502. Urgent care claims may be appealed orally. If You have an Urgent Care Claim You want to appeal, or if You have any questions about the appeal process, please call 775.770.9312 / 800.433.3077, Hours of Operation: 8 a.m. – 5 p.m. Monday – Friday.

If You believe that Your appeal qualifies as an Urgent Care Claim, You should also inform PPHIC that You believe Your appeal should be expedited.

If You fail to Appeal a denial within the 180-day period, PPHIC's initial claim determination will

be final and binding. If You are physically incapacitated during the Appeal timeline and Your authorized representative was unable to submit the Appeal on Your behalf, then You are entitled to an additional 60 days to submit Your Appeal. Upon request, PPHIC will assign an Appeal's Specialist to assist You (or Your Representative) through the appeal process.

The Appeal will be reviewed by the Appeals Committee. An Appeals Committee Member's compensation, promotional opportunities or other terms and conditions of employment have no relationship to whether a Member's appeal is granted or denied. If You Appeal, You (or Your authorized representative) may submit comments, documents, records or other information You feel are pertinent to permit the Appeals Committee to re-examine all facts and make a determination with respect to the denial. As a PPHIC Member, You may request reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. In addition, You may request reasonable access to all documents submitted on Your behalf to the Appeals Committee. Upon request, You can obtain a copy of the benefit provisions, guidelines or protocols on which the denial decision was based. The member or the member's designated representative may appear in person or by teleconference to present information to the Appeals Committee.

In order to ensure the prompt and fair processing of Member Appeals, the time period for filing Appeals and reviewing Appeals is fixed. The beginning date for Member Appeals is that date on which PPHIC receives notification of a Member's Appeal and ends on the date PPHIC notifies the Member of its decision. Given the tight time schedules established in the claims procedures, PPHIC cannot extend time deadlines.

Additional materials submitted after the time has expired for submitting Your Appeal cannot be considered.

ii. **Appeal:** Your Appeal will be reviewed and the decision made by someone not involved in the initial denial of Your claim. The Appeals Committee will consult with an appropriate healthcare professional who was not involved in the initial denial of Your claim with respect to Appeals involving medical judgment. The Appeals Committee will not afford deference to the initial claim denial. In the event new or additional evidence is considered, relied on or generated by the Plan or Appeals Committee in connection with a Member's claim, then as soon as possible and at least 14 calendar days in advance of the date of the Appeals Committee decision, the Member will be provided, free of charge, with the new evidence or the new rationale. A Member may respond to the new evidence or rationale before a decision is made by the Appeals Committee. The Appeals Committee will provide written or electronic notification of its decision within 30 calendar days after it receives an Appeal for a pre-certification claim or a post-service claim. In the case of an Urgent Care Claim Appeal, PPHIC will either respond orally with a decision within 72 hours, followed up by written or electronic notification, or will provide written confirmation of its decision within 72 hours.

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

01. A notice of Adverse Benefit Determination will include information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), and a statement notifying the claimant that they may request their diagnosis and treatment code(s) as well as the code's corresponding meaning(s). PPHIC will provide such codes and corresponding meanings as soon as practicable after receipt such requests. Requests for diagnosis and treatment code(s) and corresponding meaning(s) are merely information requests and will not trigger the start of an external review,
02. The specific reason or reasons for the Adverse Benefit Determination on Appeal,
03. Reference to the specific Plan provisions upon which the determination is based,
04. A statement that You may request access to, and copies of, all documents, records and all other information relevant to Your claim,
05. If an internal rule, guideline, standard, protocol or other similar criterion was relied upon in denying Your claim, a copy of that statement will be provided free of charge upon request,

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

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

08. A statement of Your right to bring a civil action under Section 502(a) of ERISA (if applicable). Para obtener asistencia en Español, llame al 775.770.9312 / 800.433.3077.

Los avisos están también disponibles en Español a petición ara obtener asistencia en Español, llame al 775.770.9312 / 800.433.3077. Los avisos están también disponibles en Español a petición.

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

i. No legal action for benefits under the Plan may be brought until You;

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

ii. The Plan fails to establish and follow its own written procedures unless the failure was (i) de-minimis,(ii) non-prejudicial, (iii) attributable to good cause or matters beyond PPHIC's control, (iv) in the context of an ongoing good-faith exchange of information, and (v) not reflective of a pattern or practice of non-compliance. Upon written request, PPHIC will provide You with an explanation of its basis for asserting that the circumstances meet the exception. If an external reviewer or a court rejects Your request for immediate review of a claim, on the basis that PPHIC met the exception requirements listed above, You have the right to resubmit Your claim and pursue an internal appeal.

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

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

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

12. NOTICE OF APPEAL RIGHTS UNDER NEVADA LAW

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

You may request an additional explanation when Your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment You received was not fully covered. Contact us at 775.770-9312 or 800.433.3077 when You:

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

If Your claim was denied due to missing or incomplete information, You or Your health care provider may

resubmit the claim to us with the necessary information to complete the claim.

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

Emergency Experimental or Investigational Medical Conditions: In the event of emergency experimental or investigational medical conditions, the time frame for completing the expedited review for urgent claims either internally or externally does not apply. Emergency medical conditions are those that would jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function. Review for requests of emergency experimental or investigational medical treatment may be made at the same time a request for an expedited review of a denied claim has been made both internally and externally. If the initial denial of the claim for emergency experimental or investigational treatment involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and if the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment (the subject of the initial claim denial) would be significantly less effective if not promptly initiated, then the independent review organization assigned to conduct the expedited external review will decide whether the Covered Person will be required to complete the expedited review of the denied claim before medical services are provided.

13. External Review of Denied Claims

If PPHIC has denied Your request for the provision of or payment for a health care service or course of treatment You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment You requested by submitting a request for external review within four months after receipt of this notice to the

Office for Consumer Health Assistance (OCHA)
555 East Washington #4800
Las Vegas, NV 89101
Phone: 702.486.3587 / 888.333.1597, or Fax 702.486.3586
Web: dhhs.nv.gov/Programs/CHA/

14. Standard External Review

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

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

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

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

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

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

iv. If applicable, a list that specifies each Provider who provided healthcare to the Member and the corresponding medical records from the Provider relating to the adverse determination.

Within five (5) days after the IRO receives the required documentation from PPHIC, 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 PPHIC within one (1) business day after receipt. The IRO shall approve, modify, or reverse the adverse determination within fifteen (15) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:

v. Member;

vi. Member's Physician;

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

viii. PPHIC

Expedited External Review

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

i. An inpatient admission;

ii. Availability of inpatient care;

iii. Continued stay or health care service for Emergency Services while still admitted to an inpatient facility; or

iv. Failure to proceed in an expedited manner may jeopardize the life or health of the Member.

The OCHA shall approve or deny this request for Expedited External Review within seventy-two (72) hours after receipt of the above required proof. If OCHA approves the request, it shall assign the request to an IRO no later than one (1) business day after approving the request. PPHIC 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 PPHIC agree to a longer time period.

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

v. Member;

vi. Member's Physician;

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

viii. PPHIC

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

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

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

Standard External Review

f. The Member or Member's Authorized Representative may within four (4) months after receiving

notice of an adverse determination subject to this section, submit a request to the OCHA for an External Review.

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

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

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

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

   i. Member;

   ii. Member's Physician;

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

   iv. PPHIC

Expedited External Review

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

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

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

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

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

p. The clinical reviewers have no more than five (5) days to provide an opinion to the IRO. The IRO has forty-eight (48) hours to review the opinion of the clinical reviewers and make a determination. The IRO shall notify the following parties no later than twenty-four (24) hours after completing its External Review:

    i. Member;

    ii. Member's Physician;

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

    iv. PPHIC

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

Office for Consumer Health Assistance 702.486.3587 in the Las Vegas area / 1.888.333.1597 outside the Las Vegas area (toll free).

Part XIV. Notice of Privacy Practices

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

If You have questions about this notice please contact:

Scott Heinze - Privacy Officer
Prominence Preferred Health Insurance Company
1510 Meadow Wood Lane
Reno, Nevada 89502
t: 775.770.9444
f: 775.770.9360

WHO WE ARE
This Notice describes the privacy practices of PPHIC and applies to any health services You receive through the PPHIC.

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

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

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

WHEN PPHIC MUST DISCLOSE YOUR PHI
PPHIC must disclose Your PHI:

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

HOW WE PROTECT YOUR PHI
PPHIC protects personal health information (PHI) in the following ways:

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

   WHEN PPHIC MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION PPHIC may use and/or disclose Your PHI as follows:

1. **For Treatment.** PPHIC does not provide medical treatment directly, but it may disclose Your PHI to a health care provider who is giving treatment. For example, PPHIC may disclose the types of prescription drugs You currently take to an emergency room Practitioner, if You are unable to provide Your medical history due to an accident. In addition, We may contact You to tell You about other health-related benefits and services that might interest You.
2. **For Payment.** PPHIC may use and disclose PHI, as needed, to pay for Your medical benefits. For example, PPHIC may tell a doctor whether You are eligible for coverage or what percentage of the bill PPHIC might pay. PPHIC may also use or disclose Your PHI in other ways to administer benefits; for example, to process and review claims, to coordinate benefits with other PPHIC, including Medicare, or Medicaid, and to do utilization review and pre-authorizations.
3. **For Healthcare Operations.** PPHIC may use and disclose Your PHI to make sure PPHIC is well run, administered properly and does not waste money. For example, PPHIC may use information about Your claims to project future benefit costs or audit the accuracy of its claims processing functions. PPHIC may also disclose Your PHI for a claim under a stop-loss or re-insurance policy. Among other things, PPHIC may also use Your PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits.
4. **For Special Information.** In addition to the Privacy Rule, special protections under state or other Federal laws may apply to the use or disclosure of Your PHI. PPHIC will comply with these state or federal laws where they are more protective of Your privacy.
5. **For Payment.** PPHIC may use and disclose PHI, as needed, to pay for Your medical benefits. For example, PPHIC may tell a doctor whether You are eligible for coverage or what percentage of the bill PPHIC might pay. PPHIC may also use or disclose Your PHI in other ways to administer benefits; for example, to process and review claims, to coordinate benefits with other health plans, including Medicare, or Medicaid, and to do utilization review and pre-authorizations.
6. **To Your Other Health Care Providers.** We may also share PHI with Your doctor and other health care providers when they need it to provide treatment to You, to obtain Payment for the care they give to You, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.
7. **To Business Associates.** PPHIC may hire third parties that may need Your PHI to perform certain services on behalf of PPHIC. These third parties are "Business Associates" of PPHIC. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, PPHIC . For example, PPHIC may hire a third-party administrator to process claims, an auditor to review how an insurer or third party administrator is processing claims, or an insurance agent to assess coverage and help with claim problems.
8. **To Individuals Involved with Your Care or Payment for Your Care.** PPHIC may disclose Your PHI to adult members of Your family or another person identified by You who is involved with Your care or payment for Your care if: 1) You authorize PPHIC to do so; 2) PPHIC informs You that it intends to do so and You do not object; or 3) PPHIC infers from the circumstances, based upon professional judgment, that You do not object to the disclosure. Whenever possible, PPHIC will try to get Your written objection to these disclosures (if You wish to object), but in certain circumstance it may rely on Your oral agreement or disagreement to disclosures to family members.
9. **To Personal Representatives.** PPHIC may disclose Your PHI to someone who is Your personal representative. Before PPHIC will give that person access to Your PHI or allow that person to take any action on Your behalf, it will require him/her to give proof that he/she may act on Your behalf; for example, a court order or power of attorney granting that person such power. Generally, the parent of a minor child will be the child's personal representative. In some cases, however, state law allows minors to obtain treatment (e.g., sometimes for pregnancy or substance abuse) without parental consent, and in those cases PPHIC may not disclose certain information to the parents. PPHIC may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Individual Rights. You have certain rights under the Privacy Rules relating to Your PHI maintained by PPHIC. All requests to exercise those rights must be made in writing to the Privacy Officer. PPHIC's insurers and PPO's keep their own records and You must make Your requests relating to You PHI in those records directly to that insurer or PPO. Your rights are:

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

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

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

You may also send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. Our Facility Privacy Officer can provide You the address. He will not take any action against You for filing a privacy complaint. To file a privacy complaint with the Secretary of the DHHS, You must submit Your privacy

complaint in writing, either on paper or electronically, within 180 days of the date You knew or should have known that the violation occurred. You must state who You are complaining about and the acts or omissions You believe are violations of the Privacy Rules.

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

Health Information not Covered by this Privacy Notice.

This Privacy Notice does not cover:

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

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

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

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

Scott Heinze – Privacy Officer
Prominence Preferred Health Insurance Company
1510 Meadow Wood Lane
Reno, Nevada 89502
t: 775.770.9444
f: 775.770.9360

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

Michael Leoz, Regional Manager
Office for the Civil Rights (Region IX - Nevada)
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
t: 800.368.1019
f: 415.437.8329

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

Consumer Health Assistance
555 East Washington Avenue, Suite 4800
Las Vegas, Nevada 89101
t: 702.486.3587 or 800.333.1597

Part XV. General Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part XVI. Mediation and Arbitration Agreement

Dispute Resolution

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

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

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

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

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

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

7. Either You or PPHIC may initiate arbitration with respect to the matters submitted to mediation by filing a written demand for arbitration at any time following the initial mediation session or 45 days after the date of filing of the initial written request for mediation, whichever occurs first. The provisions of Part XVI may be enforced by any court of competent jurisdiction, and the party seeking enforcement shall

be entitled to an award of all costs, fees and expenses, including attorney's fees, to be paid by the party against whom enforcement is ordered.

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

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

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

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

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

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

Notice of A Dispute

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

Arbitration Procedure and Rules

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

award is based. Except as otherwise provided for herein, PPHIC will pay all AAA filing, administration, and arbitrator fees for any arbitration initiated in accordance with the Notice requirements above. The arbitrator may award declaratory or injunctive relief only in favor of the individual party seeking relief and only to the extent necessary to provide relief warranted by that party's individual claim.

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

Civil Complaint

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

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

9. In addition, notwithstanding any provision in this Mediation/Arbitration Agreement to the contrary, the Parties agree that if PPHIC makes any future changes to this arbitration provision (other than a change to the Notice Address) during the term of this Mediation/Arbitration Agreement, You may reject any such change by sending PPHIC written notice within thirty (30) days of the change to the Notice Address provided above. By rejecting any future change, You are agreeing that You will arbitrate any dispute between us in accordance with the language of this provision.

Part XVIII. Eligibility, Enrollment, and Effective Date of Coverage

A. Eligible Pediatric Dependents

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

Be the Subscriber's child up to age 19. The term child includes natural children, step-children, and children for whom You have been appointed by the court as permanent legal guardian, or children who have been legally adopted or are awaiting finalization of adoption by You; or

Be an unmarried child who is (and continues to be) both (1) incapable of self-sustaining employment due to physical handicap or mental retardation and (2) dependent upon the Subscriber of the insured group health plan for support and maintenance. This condition must have occurred before the child reaches age 19. Proof of this incapacity must be furnished to PPHIC within 31 days after attainment of the limiting age and then once a year beginning 2 years after the dependent has reached the limiting age.

2. Non-eligible Pediatric Dependents are defined as persons to include a foster child, a child placed in the Subscriber's home (except those placed for adoption), a grandchild of Subscriber or Subscriber's spouse, a Dependent that is a full-time member of the Armed Forces of any country, an emancipated minor (as defined by Nevada law), legal wards (except those legal wards permanently placed in Subscriber's home by court order), and individuals whom You are the authorized Power of Attorney as appointed by the courts. Parents and/or relatives of the Subscriber or Subscriber's spouse are not considered eligible Dependents.

3. Adopted or placed Pediatric Dependents will be covered as of the date the adoption becomes effective or the date the child is placed in the home whichever occurs first. An enrollment form must be completed within 31 days of the event. Certification by the adoption or placement agency will be required.

4. Marriage, remarriage and/or newly acquired Pediatric Dependents (e.g. stepchildren) will be covered only if an enrollment form is received within 31 days from the date of marriage.

B. Enrollment

1. No person meeting Pediatric Dependent eligibility requirements will be refused enrollment or reenrollment by PPHIC because of health condition, or need for dental services.

2. Initial Enrollment: As an employee of the Group, You are entitled to Pediatric Dental coverage provided under this plan. All eligible Pediatric Dependents must be listed on the enrollment form.

3. Group Open Enrollment: A Group Open Enrollment Period shall be held for at least 15 days once every 12 months at which time You may enroll your eligible Pediatric Dependents of PPHIC.

4. Notice of Ineligibility: It is your responsibility to notify PPHIC of any changes that affect Pediatric Dependents within 31 days of a qualifying event.

5. Limitation: Persons initially or newly eligible for enrollment that do not enroll within 31 days of eligibility may only be enrolled during the next Group Open Enrollment Period, unless a qualifying event occurs.

C. Effective Date of Coverage

After PPHIC receives a completed enrollment form, and the appropriate premium arrangements are made, coverage under this Schedule of Covered Services shall begin on the earliest of the following dates:

1. Initial Enrollment and Open Enrollment: Coverage shall begin on the date agreed upon by the Group and PPHIC.

2. Newly Eligible Pediatric Dependents: Coverage will begin on the first day of the month following enrollment or the Group's established eligibility date. Coverage will begin as of the date of the event such as marriage, adoption, or guardianship, ONLY if the enrollment form is received within 31 days from the date of the event. Newly eligible Dependents not added within the 31 days, may not be added until the next Group Open Enrollment Period, unless a Qualifying Coverage event occurs as described in Part II, (Sections A & B) of this Schedule of Covered Services. The effective date of coverage as noted in (1) and (2) above, may be changed by agreement of the Group and PPHIC. PPHIC will provide you with a Pediatric Dental Schedule of Covered Services and other Member materials upon enrollment.

Part XIX. Pediatric Dental Expenses & Services

Dental Expenses means the charges for the Dental Services and supplies provided by your Dental Professional and listed below. For Dental Benefits please see Your Pediatric Dental Summary of Benefits, including the limitations and exclusions that are specific to you. Dental benefits are a percentage of the maximum allowable charges for the dental services listed below after any applicable deductible as provided in Your Pediatric Dental Summary of Benefits. No dental services are available when generally considered under the medical plan.

PEDIATRIC DENTAL SUMMARY OF BENEFITS – WHAT THE DENTAL PLAN PAYS

INFORMATION	PPO Network	Non-PPO
Calendar-year deductible	Medical deductible/Individual	Medical deductible/Individual
Calendar-year family deductible	Medical deductible/Family	Medical deductible/Family

Out of Pocket Maximum Limit:
Pediatric Dental Service Copayments, Coinsurance, and Deductibles Accrue toward the Out-of-Pocket Maximum Limit on the Medical Plan

	PPO Network	Non-PPO
DIAGNOSTIC AND PREVENTIVE SERVICES *(Diagnostic and preventive services not subject to deductible)*	100%	70%

- Oral Examinations (once every 6 months)
- Prophylaxis (routine cleanings once every 6 months)
- Sealants (for children up to age 18)
- Fluoride Treatments (for children to age 16 – once every 6 months)
- X-rays (Intraoral – complete series; Bitewing – single film and Periapical)

	PPO Network	Non-PPO
BASIC RESTORATIVE PROCEDURES *(subject to deductible)*	80%	50%

- Amalgam & Composite Restorations (once every five years unless unserviceable)
- Periodontics (treatment of gum disease; surgical or non-surgical – once every three years)
- Endodontics (root canal treatment – permanent teeth; pulpotomy – primary (baby) teeth)
- Basic Oral Surgery (extraction of Teeth-erupted tooth or exposed root)
- Complex Oral Surgery (surgical removal of erupted tooth, impacted tooth and tooth roots)
- Anesthesia (in conjunction with complex oral surgery)
- Emergency Palliative Treatment (treatment for the relief of pain)
- Space Maintainers (once per lifetime for missing posterior primary (baby) teeth up to age fourteen (14); includes one (1) adjustment within six (6) months of placement.)

	PPO Network	Non-PPO
MAJOR RESTORATIVE PROCEDURES *(subject to deductible)*	50%	20%

- Fixed Prosthodontics (crowns, inlays and onlays)
- Removable Prosthodontics (complete and partial dentures, bridgework)
- Prosthodontic Repair and Replacement (denture relines and rebases, bridgework; a five (5) year waiting period applies to all major services including lost, misplaced or stolen bridges or dentures, and replacement restorations)
- Benefits for implants are only available when no alternative form of therapy exists to treat the dental condition, and only if approved by independent dental consultants.)

	PPO Network	Non-PPO
ORTHODONTIA *(not subject to deductible)*	50%	20%

Out-of-Pocket Maximum Limit:
Orthodontia services covered up to the Out-of-Pocket Maximum Limit on the Medical Plan

Non-participating dentists can bill you for charges above the amount covered by your PPHIC's PPO Dental plan. To ensure you do not receive additional charges, visit a participating PPO Network dentist. Pretreatment Estimate of Dental Benefits: Treatment Plans in excess of $300 should be submitted to PPHIC for a review of available dental benefits available.

A. Covered Diagnostic and Preventive Dental Services

1. 1. Oral examinations (once every six (6) months)

2. 2. Prophylaxis (cleanings - once every six (6) months)

3. 3. Application of sealants for a dependent child under the age of 18 years and only to the occlusal surface of permanent molars that are free of decay and restorations, but only once in any three (3) year period.

4. 4. Fluoride treatments (for children to age 16, once every 6 months)

5. 5. Dental X-rays as follows:
   - One set of full mouth or panoramic X-rays in any three (3) year period;
   - One set of bitewing X-rays twice in a twelve (12) month period;
   - Periapical X-rays
   - One set of Occlusal X-rays in a three (3) year period.

6. Space Maintainers – are provided once per lifetime for missing posterior primary (baby) teeth up to age fourteen (14); includes one (1) adjustment within six (6) months of placement. Orthodontic space maintainers are not included.

B. Covered Basic Restorative Service

1. Amalgam restorations (once every five (5) years unless unserviceable) – multiple restorations on one surface are considered one restoration.

2. Composite restorations (once every five (5) years unless unserviceable) – multiple restorations on one surface are considered one restoration.

3. Basic Oral Surgery – Simple extraction of one or more teeth including coronal remnants of a deciduous tooth and/or erupted tooth or exposed root.

4. Endodontic treatment, including pulpotomy, apicoectomy, retrograde filling, and root canal therapy– procedures available to permanent teeth only. Vital pulpotomy - procedure available for deciduous (baby) teeth only. Charges for root canal therapy for which the pulp chamber was opened before the effective date of your Insurance will not be covered.

5. Periodontal services and treatments as follows:
   - Root scaling and root planing, available at a maximum of once per quadrant in a three (3) year period.
   - Periodontal cleaning/maintenance (following periodontal therapy) – procedure available twice per year up to a maximum of three (3) years following last periodontal therapy received.
   - Occlusal adjustment if performed in conjunction with covered periodontal surgery available at a maximum of once per quadrant in a three (3) year period.
   - Gingivectomy, gingival curettage, and mucogingival surgery – available at a maximum of once per quadrant in a three (3) year period. If more than one surgical service is performed on the same day, we will consider only the most inclusive service performed as a covered service.

- Osseous surgery including flap entry and closure- available at a maximum of once per quadrant in a three (3) year period. If more than one surgical service is performed on the same day, we will consider only the most inclusive service performed as a covered service.
- Pedicle or free soft tissue grafts.
- Periodontal appliances, but only one in any five (5) year period
- Bone grafts, either single or multiple
- Provisional splinting, either intracoronal or extracoronal
- Gross debridement is allowed one time at the beginning of a periodontal treatment plan, prior to pocket depth charting. Subsequent requirement for debridement is considered patient neglect and would be the financial responsibility of the Insured.

6. Complex Oral Surgery Services include:
   - Surgical Extraction of one or more teeth
   - Extraction of the tooth root
   - Alveolectomy, alveoplasty and frenectomy
   - Mobilization of erupted or malpositioned tooth to aid eruption; or, surgical reposition of teeth
   - Excision or removal of benign oral cysts or tumors and incision and drainage of an abscess or cyst
7. General Anesthetics, analgesics, and intravenous sedation when given as part of covered Complex Oral Surgical procedures. General anesthesia is not a covered expense unless it is medical necessity and administered by a dentist in conjunction with covered complex oral surgical procedures outlined in this section. Patient management or apprehension is not considered a medical necessity.
8. Emergency palliative treatment – treatment for the initial palliative care of pain and/or injury. Services include palliative procedures for treatment to the teeth and supporting structures. We will consider the service as a separate benefit only if no other service, except X-rays, is provided during the same visit.

C. Covered Major Restorative Service

1. Repairs of bridges, full or partial dentures, and crowns.
2. Initial placement of laboratory – fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement filling material. Covered services include inlays, onlays, crowns, veneers, core build-ups and posts. These services are covered only on permanent teeth. We will not cover the expense incurred for pin retention when done in conjunction with core build-up.
3. Initial placement of bridges, and full and partial dentures only if the functioning tooth (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) was extracted while you are covered under this plan. Covered services include fixed bridges, removable partial dentures and full dentures. Services include all adjustments and relines within six (6) months after installation and are payable only for treatment on permanent teeth. We will not cover replacement of congenitally missing teeth.
4. Replacement of bridges, partials, dentures, inlays, onlays, crowns or other laboratory- fabricated restorations. The existing major restoration or prosthesis can be replaced only if:
   - It has been at least five (5) years since the prior insertion and is not, and cannot be made, serviceable
   - It is damaged beyond repair as a result of an accidental dental injury (non-chewing injury) while in the oral cavity; or
   - Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis, necessitates the replacement of the prosthesis.
   - These services are covered only on permanent teeth. No dental benefit will be paid for any duplicate prosthetic appliance or the replacement of any lost, missing, or stolen prosthesis or appliance.
5. Denture relines or rebases – once in a three (3) year period and after 6 months from installation.

6. Implants must be performed in conjunction with a covered prosthesis. Benefits for implants are available only when no alternate form of therapy exists to treat the dental condition, and only if approved by independent dental consultants.

7. Appliances for children under Age 15 – Fixed and removable appliances to inhibit thumb sucking and other harmful habits. Eligible services are covered only for dependents up to age 15 for the installation of the initial appliance. Separate adjustment expenses will not be covered.

8. Non-cast pre-fabricated crowns – service on primary teeth that cannot be adequately restored with amalgam or composite restorations.

9. Recementing of inlays, onlays crowns and bridges.

10. Denture Adjustments – procedure available only for adjustments done by a dentist other than the one providing the denture, or adjustments performed more than six months after initial installation.

11. Repairs of full or partial dentures.

D. Orthodontic Dental Services

1. Orthodontic Dental Expenses means charges for the following services and supplies:
    - Cephalometric film
    - Removable, fixed or cemented appliance for tooth guidance or for interceptive orthodontic treatment, including impressions, installation and all adjustments within 6 months of installation.
    - Comprehensive (full-banded) orthodontic treatment of transitional or permanent teeth.

2. No Dental Benefits will be paid for Orthodontic Dental Expenses incurred after the date dental insurance ends.

3. Orthodontics for child(ren) is an eligible benefit to age 19.

4. Takeover Provision: If the first active orthodontic appliance was placed prior to the Group Policy Effective Date, Dental Benefits will be paid for Orthodontic Dental Expenses if:
    - Orthodontic Dental Expenses are incurred after the Group Policy Effective Date; and
    - Dental Orthodontic Benefits were payable under the Policyholder's group dental insurance program immediately prior to the Group Policy Effective Date.

Integral service

The following services are considered integral to the pediatric dental service that may be provided in Your Summary of Benefits. A separate fee for these services is not considered a covered expense.

1. Local anesthetics;
2. Bases;
3. Pulp caps;
4. Temporary dental services;
5. Study models/diagnostic casts;
6. Treatment plans;
7. Nitrous oxide;
8. Irrigation;
9. Tissue preparation associated with impression or placement of a restoration.

Part XX. Pediatric Dental Plan Exclusions and Limitations

Based upon dental services covered, no benefits are payable under this Policy for the procedures listed below. Additionally, the procedures listed below will not be recognized toward satisfaction of any Deductible Amount.

1. Procedures (including crowns, bridges, dentures and root canals) started prior to the date the Member became eligible for such services under this Agreement.
2. The replacement of lost, missing, or stolen prosthesis or appliance except as provided in the Service Limits within Your Schedule of Pediatric Dental Services.
3. Replacement of prosthetic appliances (including full or partial dentures and bridges, crowns, inlays and onlays) except as provided in the Service Limits within Your Schedule of Pediatric Dental Services.
4. Appliances, services or procedures relating to: the change or maintenance of vertical dimension; restoration of occlusion; splinting; correction of attrition or abrasion; bite registration or bite analysis; orthognathic surgery; treatment for jaw fracture; gnathological reporting, full mouth equilibration; prosthodontic specialty services, temporary processed functional crowns/appliances and realignment of teeth, except as provided in the Service Limits within Your Schedule of Pediatric Dental Services.
5. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain except as provided in the Service Limits within your Schedule of Pediatric Dental Services.
6. Prescription drugs, premedication, except as provided in the Service Limits within Your Schedule of Pediatric Dental Services.
7. Any instruction for diet, plaque control, oral hygiene, and behavior management except as provided in the Service Limits within Your Schedule of Pediatric Dental Services.
8. Dental disease, defect or injury caused by a declared or undeclared war or any act of war.
9. Charges for: implants of any type, and all related procedures, removal of implants, precision or semi- precision attachments, denture duplication, over dentures and any associated surgery, or other customized services or attachments; surgical grafting procedures and maxillofacial dental services, except as may be provided for within Your Schedule of Pediatric Dental Services.
10. Cast restorations and crowns for teeth that are not broken down by extensive decay or accidental dental injury or for teeth that can be restored by other means.
11. For treatment of malignancies, cysts and neoplasms except as provided within Your Schedule of Pediatric Dental Services.
12. For orthodontic treatment except as provided within your Pediatric Dental Summary of Benefits.
13. Charges for failure to keep a scheduled visit or for the completion of any claim forms.
14. Procedures considered experimental, investigative in nature, and not proven to be effective, as determined by Prominence Preferred Health Insurance Company, Inc. or not provided within Your Schedule of Pediatric Dental Services.
15. Service or supply rendered by someone who is related to an Insured Person by blood (e.g., sibling, parent, grandparent, child, marriage (e.g. spouse or in-law,) or adoption or is normally a member of the Insured Person's household.
16. Any procedure, service or supplies which are included as covered medical or dental expenses under another group medical expense benefit plan, except as provided through the coordination of benefits provision within the policy.
17. Expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-fault" coverage), except as to charges which the person is legally obligated to pay.

18. Conditions caused by medical care of hospitalization.
19. Hospital expenses and services requiring treatment in a hospital (including emergency room) except as provided within Your Schedule of Pediatric Dental Services.
20. Extractions of non-pathologic asymptomatic teeth, including extractions for orthodontic reasons, except as provided within Your Schedule of Pediatric Dental Services.
21. Services for any dental treatment performed outside the United States or Canada except for emergency treatment.
22. Routine chest x-rays and medical exams prior to oral surgery.
23. Routine teeth cleaning (prophylaxis and scaling) more than once every six months.
24. Services that cannot be performed in the dental office because of patient physical, medical or behavioral limitations, unless medical necessity is determined by the Utilization Department and the Medical Director.
25. Acrylic resin for restorations and crowns will not be covered on posterior teeth.
26. Sealants for children less than age 19 are limited to one treatment per tooth once in a lifetime.
27. Fluoride applications for children less than age 19 are limited to once in a six (6) month period.
28. More than one set of full-mouth X-rays or its equivalent per insured person in a three (3) year period.
29. Bitewing X-rays once every six months.
30. Periapical as needed, except as provided within Your Schedule of Pediatric Dental Services. Periapical and bitewing X-rays submitted individually will be combined and paid up to the amount of a full mouth series and are subject to the full mouth X-ray limitation.
31. Claims received after 12 months from the date service was rendered.
32. Fillings exceeding one every thirty-six (36) months per surface per tooth unless unserviceable.
33. Replacement of existing fillings for any purpose other than restoring active decay.
34. Space maintainers are allowed 2 units per 12 months, 4 units per lifetime.
35. Periodontal scaling and root planing will be limited to 4 units per 12 months once. Polishing of all teeth is considered part of this treatment.
36. Periodontal surgery exceeding 4 units per 60 months.
37. Gross debridement is allowed at the beginning of a periodontal treatment plan, prior to pocket depth charting.

Part XXI. Administration

A. The relationship between PPHIC and Plan Practitioners/Dentists is that of an independent contractor relationship. Plan Practitioners/Dentists are not agents of PPHIC, nor is PPHIC or any of its employees, an employee or agent of Plan Practitioners/Dentists. PPHIC shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with, any injuries suffered by you while receiving care through any Plan Practitioner/Dentist.

B. PPHIC reserves the right to revise this Schedule of Covered Services and Pediatric Dental Summary of Benefits, in accordance with state regulatory agencies. Such revisions shall be made upon 60 days prior written notice to the Group.

C. Identification cards are issued for the purpose of identification only. If you willfully or knowingly permit another person to use your identification card, no benefits will be paid for those services and your coverage will be terminated.

Part XXII. Termination of Coverage

A. Group Coverage, including this Schedule of Covered Services, may be terminated in the following ways:

1. By the Group, for any reason with 31 days written notice to PPHIC.
2. By PPHIC, if the Group fails to pay the premium for this Schedule of Covered Services when due, and if default continues after the Grace Period, the Group and all Members enrolled through the Group may be terminated.
3. By PPHIC, or the Group, if the Group, or a covered subsidiary, is no longer doing business in the geographical Service Area.
4. By PPHIC, for any reason detailed in this Schedule of Covered Services or any reason required by an applicable regulatory agency upon 60 days written notice.
5. By the Group, in writing, within 31 days of notice of increase in premium.

B. A Pediatric Dependent's coverage may be terminated in the following ways:

1. By the Group, if You are no longer eligible for Group coverage.
2. By PPHIC, if the Group is no longer eligible to have a contract with PPHIC.
3. By PPHIC, for failure to make payment of premiums or other charges due to the Health Plan or a Plan Practitioner, upon 31 days written notice.
4. Please be advised that any person who makes any materially false statements in regards to this Health Plan may be terminated.
5. By Group, Subscriber or PPHIC for any Pediatric Dependent Member who is no longer eligible for coverage as a Dependent
6. By PPHIC, if You willfully and knowingly permit another person to use Your identification card.

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

A. **Nonduplication:** PPHIC will provide you with full dental care services within the limits of this Schedule of Covered Services. PPHIC does not duplicate benefits or provide you with greater benefits than the actual expenses incurred. Benefits under this Schedule of Covered Services will be reduced to the extent that they are available or that reimbursement is payable under any other Schedule of Covered Services or policy covering You whether or not a claim is made for the benefits.

B. **Workers Compensation:** PPHIC will not pay for benefits for conditions in which coverage is available under the workers compensation law. PPHIC may arrange, however to provide access to and treatment for illness or injury. If workers compensation deems the Member's illness or injury to be nonwork related, the Member must go through the workers compensation's appeal process. Before PPHIC will consider payment of the claim, PPHIC must first receive all final determinations from workers compensation. The Member must still follow the procedures set forth in this Schedule of Covered Services.

C. **Coordination of Benefits:** It is not unusual that a Pediatric Dependent is covered under two insurance contracts that provide similar coverage. If both of the contracts are issued through or by Groups and if the service you receive is covered under both contracts, PPHIC will coordinate benefit payments with the other company. PPHIC will pay its benefits if all state-approved guidelines are followed as stated in this Schedule of Covered Services. Prior to receiving services under Coordination of benefits, contact PPHIC Customer Service department.

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

1. If the other contract does not have a provision similar to this one, then it is the primary contract.
2. If the person receiving the benefit is the Subscriber belonging to the Group through which, or to which one contract was issued and is only covered as a Dependent on the other contract, the contract under which the person is the Subscriber shall be primary.
3. If two or more contracts cover the person receiving care as a Dependent, then the contract of the Subscriber whose birthday, month of birth, follows earliest in the Calendar Year shall be primary unless the other contract uses a rule based on the Subscriber's gender and as a result, the contracts do not agree on the order of benefits. In that case, the other contract shall be primary.
4. If the Dependent is the child of divorced or separated parents, then benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child;
   c. Finally, the plan of the parent not having custody of the child; and

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

5. If none of the above applies, then the contract which has covered You or the person receiving services for the longest time shall be primary.
6. You are required to cooperate with PPHIC in the administration of this provision. If this Schedule of Covered Services requires that benefits be paid for by another source and you have failed to seek payment from that source; PPHIC will reduce the payments under this Schedule of Covered Services by the amount to which you are entitled from that source. In some cases PPHIC may ask you to sign documents or cooperate with us to seek payment from another source. You are required to cooperate in such cases.