Coventry Health and Life Insurance Company

CoventryOne®

Preferred Provider Organization (PPO)

INDIVIDUAL MEMBER CONTRACT

Under this PPO Plan, inpatient, outpatient and other Covered Services are available through both In-Network (Participating) Providers and Out of Network (Non-participating) providers. Benefits under this Plan are subject to Our Utilization Management Program.

Keep in mind that using a Participating Provider (Your In-Network benefits) will usually cost You less than using a Non-Participating Provider (Your Out-of-Network benefits) because Participating Providers are contracted with Us to provide health care services to Members for a lower fee, whereas Non-Participating Providers are not contracted with Us. Please see Section 1 for more information on how Your In-Network and Out-of-Network benefits work.

Servicio en Español
Si usted tiene preguntas acerca de sus beneficios, necesita materiales en español, o le gustaría hablar con un representante que habla español, por favor llame al 866-364-5663. El Departamento de Servicio al Cliente está a su disposición de Lunes a Viernes de las 8:00 de la mañana hasta las 5:00 de la tarde.

CoventryOne® is underwritten by Coventry Health and Life Insurance Company.
10421 South Jordan Gateway
South Jordan, Utah 84095

CHC-NV-INDV-PPO-CAT-Contract-2014
Dear New Member:

Welcome to Coventry Health and Life Insurance Company! We are extremely pleased that You have enrolled in Our CoventryOne® Plan and look forward to serving You.

Coventry Health and Life Insurance company is a subsidiary of Coventry Health Care, Inc., a Fortune 500 company operating Plans, insurance companies, network rental, and workers' compensation services companies in all 50 states and Puerto Rico. We are one of the country's largest managed health care companies providing a full range of risk and fee-based health care products and services.

Coventry Health Care's Plans emphasize wellness and preventive care. You will find that Our strong Network of area Physicians, Hospitals, and other Providers offers a broad range of services to meet Your medical needs.

As a Coventry Member, it is important that You understand the way Your Plan operates. This Individual Member Contract is an important legal document and contains the information You need to know about Your Coverage with Us and how to get the care You need. Please keep it in a safe place where You can refer to it as needed.

Please take a few minutes to read these materials and to make Your covered family Members aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at 866-364-5663 Monday through Friday, 8:00 a.m. to 5:00 p.m. You may also access Your benefit information 24 hours a day, seven days a week by registering and logging in at www.chcnvada.com.

We look forward to serving You and Your family.

Sincerely,

David W. Fields
President
Coventry Health and Life Insurance Company
Coventry Health and Life Insurance Company
Individual Member Contract

The individual Contract (hereinafter referred to as the “Contract”) between Coventry Health and Life Insurance company (hereafter referred to as the “Health Plan,” “CHL,” “We,” “Us,” or “Our”) and You is made up of the following documents:

- Individual Member Contract and any Contract amendments;
- Application Form
- Schedule of Benefits, Covered Services, and Exclusions; and
- Applicable Riders

This is to certify that, in consideration for and upon payment of the Premium rate, the individual(s) covered under this Contract are entitled to the benefits set forth under the terms and conditions in this Contract. The laws of the State of Nevada govern this Contract. This Contract is a legal document. The Covered Services and provisions described in this Contract are effective only while You are eligible for Coverage under the Contract and while the Contract is in effect. You may enroll and remain enrolled under the Contract if You meet the eligibility requirements described in Section 2 of this Individual Member Contract.

10 Day Right to Examine Contract
Please read this Contract carefully. If you are not satisfied with it for any reason, you may return it to us within ten (10) days after you receive it, together with a request for cancellation. You will be sent a full refund of any Premium. The coverage will then be void from the beginning, as if no coverage had been issued.

Renewal
Subject to the paragraph below, this Contract is renewable and may only be non-renewed and/or terminated as set forth in Section 3. You are subject to all terms, conditions, limitations, and exclusions in this Contract and to all of the rules and regulations of the Health Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Contract.

We will renew this Contract annually on January 1st of each year, subject to termination for any of the reasons stated in Section 3, or at Your own option upon thirty-one (31) days advance written notice. We may exercise our specifically reserved right under the Contract to change the Premium, benefits, exclusions, limitations, and/or services set forth in this Contract upon sixty (60) days written notice.

This Contract gives You access to both In-Network benefits, provided by Participating Providers, and Out-of-Network benefits, provided by Non-Participating Providers. Keep in mind that using Out-of-Network benefits may cost You more than using In-Network benefits. Please read Section 1 to learn more about how Your In-Network and Out-of-Network benefits work, or call Our Customer Service Department at 800-377-4161 if You have any questions.

THIS CONTRACT SHOULD BE READ AND RE-READ IN ITS ENTIRETY

Many of the provisions of this Contract are interrelated. Therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Contract have special meanings. These words will appear capitalized and are defined for You in Section 12. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Contract may be amended, as required by and in accordance with Nevada state and federal law. When this occurs, We will provide an amendment or new Contract to You. You should keep this document in a safe place for Your future reference.

HEALTH CARE REFORM

CHL is in compliance with PPACA. If any provision of PPACA conflicts with any of the provisions of this Contract, the Contract will be interpreted to be compliant with PPACA.

CoventryOne® is underwritten by
Coventry Health and Life Insurance Company
10421 SOUTH JORDAN GATEWAY
SUITE 400
SOUTH JORDAN, UT 84095
866-364-5663

CHC-NV-INDV-PPO-CAT-Contract-2014 4
SPECIAL NOTICES

WOMEN’S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act (WHCRA).

If you are receiving benefits in connection with a mastectomy, coverage will be provided according to our utilization management criteria and in a manner determined in consultation with the attending physician and the patient for the following:

- All stages of reconstruction on the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema

Under WHCRA, coverage of mastectomies and breast reconstruction benefits are subject to deductibles, copayments, and coinsurance limitations consistent with those established for other benefits under your contract. Following the initial reconstruction, any additional modification or revision is covered only to the extent that it is not otherwise limited or excluded from coverage by your contract. Revisions requested as the result of the normal aging process will not be covered.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

The Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. In general, health insurance issuers and Health Maintenance Organizations (HMOs) may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following delivery (96 hours following a delivery by cesarean section).

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Also, a health insurance issuer or HMO cannot require you or your attending provider to obtain prior authorization for your delivery or show that the 48-hour (or 96-hour) stay is medically necessary. However, a health insurance issuer or HMO may require you to get prior authorization for any portion of a stay after the 48 hours (or 96 hours).

CIVIL RIGHTS

Coventry Health and Life Insurance Company does not discriminate in the employment of staff or in the provision of health care services on the basis of race, disability, religion, gender, color, age or national origin. If you feel you have been treated unfairly or discriminated against for any reason, call the Coventry Health and Life Insurance Company Civil Rights Coordinator at 801-933-3538 or 1-800-365-1334 extension 3538.
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SECTION 1
USING YOUR BENEFITS

CoventryOne® is a Preferred Provider Organization (PPO) Product. Under this Product, We offer In-Network health care services to You through a network of Participating Providers, who have signed a Contract with Us, where they agree to provide health care services to Members. Our Participating Provider Network (hereafter referred to as the “Network”) may change from time to time. Please visit Our website at www.chcnevada.com, or You may call Our Customer Service Department at 866-364-5663, in order to find out if a Provider is a Participating Provider.

If a Provider does not have a contractual agreement with Us, the Provider is considered to be a Non-Participating Provider. Services rendered by Non-Participating Providers are covered.

Keep in mind that using a Participating Provider (Your In-Network benefits) may cost You less than using a Non-Participating Provider (Your Out-of-Network benefits). If Covered Services are provided to You by a Non-Participating Provider, those services will be paid using the Out-of-Network Rate (“ONR”). Please see Section 1.8.2 for more information on Out-of-Network Providers and the ONR.

If You receive Covered Services at an In-Network Hospital or outpatient facility, You might inadvertently receive some services from Non-Participating Providers. In this instance, We will pay for Covered Services provided by a Non-Participating Pathologist, Anesthesiologist, Radiologist, Lab or Emergency Room Physician.

1.1 Membership Identification (ID) Card. Every Plan Member receives a Membership ID card. Please carry Your Member ID card with You at all times, and present it before health care services are rendered. If Your Member ID card is missing, lost, or stolen, contact Our Customer Service Department at 866-364-5663 or visit Our website at www.chcnevada.com to order a replacement.

1.2 Your Primary Care Provider (PCP). Your Plan does not require the selection of a PCP, but We encourage You to select a PCP from the Directory of Health Care Providers. The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. This may include preventive health services, consultation with Specialists and other Providers, Emergency Services, and Urgent Care.

You can select a PCP from one of the following specialties: Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology (OB/GYN), or Pediatrics. Although an OB/GYN may be considered a PCP, many OB/GYN physicians choose not to provide primary care. If you want an OB/GYN as your PCP, ask that Provider if he or she provides primary care services.

You may choose one PCP for the entire family, or each Dependent may select a different PCP. To locate the most current Directory of Health Care Providers, please visit Our website at www.chcnevada.com. Our online Provider directory is updated at least monthly.

If you wish to change Your PCP, You must contact Our Customer Service Department at 866-364-5663. You may also visit Our website at www.chcnevada.com to make this change.

1.3 Prior Authorizations and Utilization Management. You must comply with all of the Utilization Management Program policies and procedures noted in this Section. Our Utilization Management Program is designed to help You receive Medically Necessary health care in a timely manner and at the most reasonable cost. It is an effective measure in helping to monitor the quality and cost-effectiveness of Your health care.

Our utilization management nurses review requests for non-emergent Hospital admissions, outpatient surgeries, and other outpatient procedures. Our nurses also monitor the care You receive during a Hospital stay and post discharge.

General Policies. The following policies apply to both In-Network and Out-of-Network services:
• **Except for emergencies, all Hospitalizations and certain outpatient procedures require Prior Authorization.** You must ask Your Provider to contact Us at least ten (10) days prior to a scheduled Hospital admission, outpatient surgery, or other outpatient procedure (except for emergencies) to obtain Prior Authorization. If You are admitted to a facility prior to the date Authorized by Us, then You will be responsible for all charges related to the unauthorized days.

Emergency Hospitalization does not require Prior Authorization. However, You or a family member must notify Us of Your admission within forty-eight (48) hours or as soon as reasonably possible. If you are admitted to a Non-Participating Hospital through the Emergency Room, You will be responsible only for Copayments, Coinsurance, and/or Deductibles until your condition is stabilized. You will not be responsible for the difference between the Out-of-Network Rate and the Provider’s actual billed charges.

As soon as You are stabilized, You have the option to transfer to a Participating facility. If you choose to remain at the Non-Participating facility, the charges incurred from time of stabilization until discharge may be denied.

• **We will Authorize only Medically Necessary Covered Services.** If You obtain services that are not Medically Necessary or the services are not Authorized by Us, then You will be responsible for all charges for those services.

• **Intentional material misrepresentation:** If We Authorize a service that We later determine was based on an intentional material misrepresentation about Your health status, payment of the service will be denied. You will be responsible for all charges related to that service.

• **Notification letter:** When We approve or deny a Prior Authorization request, We will send a notification letter to You and Your Provider.

• **Right to Appeal:** You have the right to Appeal any Utilization Management Program denial. Please see the Appeal procedures in Section 7.

• **Attending Physician responsibility:** Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding Your treatment.

• **The following services require Prior Authorization:**
  - All services from Non-Participating Providers (except Emergency Services)
  - Brachytherapy
  - Capsule endoscopy
  - Cardiac nuclear medicine scans
  - Chiropractic care/spinal manipulation
  - Cochlear implants
  - Cognitive function testing, psychological testing, and behavioral assessment
  - Computed tomography angiograms (CTA) and magnetic resonance angiograms (MRA)
  - Durable Medical Equipment (DME), including prosthetics, orthotics and corrective appliances
  - Examinations performed under general anesthesia
  - Eyeglasses and contact lenses
  - Genetic testing
  - Health education services
  - Home Health Care
  - Home infusion services
  - Hospice services (Inpatient and Outpatient)
  - Hyperbaric oxygen therapy services
  - Implantable medications and devices
  - Injectable Medications (excluding Imitrex, insulin, glucagon kits and bee sting kits)
- Inpatient Facility admissions
- Inpatient rehabilitation admissions
- Intima media thickness testing (IMT)
- Intraoperative electrophysiological monitoring
- Magnetoencephalography (MEG)
- Medical coverage of dental services
- Medical nutrition therapy
- Mental health/substance abuse services – Contact MHNet at 800-701-8663
- Neuropsychological testing
- Occupational therapy, including evaluation
- Orthotics, prosthetics and corrective appliances
- Outpatient Facility or office surgeries and procedures
- Pain management services
- Physical therapy, including evaluation
- Plastic surgery and related procedures (cosmetic procedures, acne surgery, skin tag removal, and similar procedures)
- Positron-emission tomography (PET) scans
- Proton beam therapy
- Skilled Nursing Facility admissions
- Sleep studies
- Speech therapy, including evaluation
- Telemedicine services
- Three-dimension imaging
- Transplants, including initial evaluation and donor testing
- Transportation (non-urgent)

Certain Prescription Drugs require Prior Authorization, regardless of where they are provided or administered. To get a complete list of drugs that require Prior Authorization, please call the CHL Customer Service Department at 866-364-5663, or visit the CHL website at www.chcnevada.com.

**Prior Authorization requirements are subject to change from time to time.** Please ask Your Provider to call Customer Service at 866-364-5663 to determine whether a Covered Service requires Prior Authorization. The Prior Authorization phone number is located on the back of Your Member ID Card.

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**It is Your responsibility to ensure that Your Provider contacts us to obtain Prior Authorization. Please call Our Customer Service Department at 866-364-5663 to determine whether a Covered Service requires Prior Authorization.**

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When You or Your Dependents receive care from a Participating Provider, the Participating Provider is responsible for following the Utilization Management policies and procedures. However, it is Your responsibility to ensure all Prior Authorizations have been obtained prior to receiving services. Failure to obtain Prior Authorization before receiving services may result in a denial of benefits if the Health Plan, upon reviewing a claim for benefits, determines that the services provided are not Medically Necessary, are Experimental or Investigational, are cosmetic in nature, or are otherwise not Covered. Your Provider may bill you for the denied charges. If Prior Authorization was not obtained, but the Health Plan determines upon review that the services provided are Covered, you will be responsible for any Deductible, Copayment, and/or Coinsurance for those Covered Services provided by a Participating Provider.

**1.4 Refusal to Accept Recommended Treatment.** You may refuse to accept recommended care or services. CHL may regard unreasonable refusal as obstructing the provision of proper medical care under this Contract. If You refuse to accept recommended care or service, and the Provider, in agreement with the CHL Medical Director and in accordance with generally accepted standards
of medical practice in the United States, believes that such refusal is unreasonable and that no professionally acceptable alternative exists, You will be so advised. If You still refuse to accept the recommended care or service, neither CHL nor the Provider will have further responsibility to provide or pay for any care or service for the condition under treatment or for any condition caused or aggravated by such refusal.

1.5 Access to Services. We make every effort to ensure that Your access to Covered Services is quick and easy and the services are reasonably available. If You wish to see a particular Provider that is not accepting new patients or is no longer participating in Our Network, please call Our Customer Service Department at 866-364-5663. We can help You find another Participating Provider that meets Your needs. You may also nominate Your Non-Participating Provider to become a Participating Provider with CHL. Please call Our Customer Service Department for more information.

Continuity of care is especially important to Us. If You are under the care of one of Our Participating Providers and that Provider stops participating with Us, We will advise You of the termination within thirty (30) days of the date We are notified of the termination. You may continue to be Covered for otherwise Covered Services by that Provider if You are actively undergoing a Medically Necessary active course of treatment and You and the Provider agree that the continuity of care is desirable.

Coverage will be provided until the later of:

The 120th day after the date the Provider’s contract is terminated; or
If the medical condition is pregnancy, the 45th day after:
   The date of delivery; or
   If the pregnancy does not end in delivery, the date of the end of the pregnancy.

The provisions above shall apply only if the treating Provider agrees to continue to be bound by the terms, conditions and reimbursement rates of the Provider’s agreement with the Plan.

During such period of continuation coverage, You shall not be liable to the Provider for any amounts owed for medical care other than Copayments, Coinsurance, and/or Deductibles specified under the terms of the Agreement.

1.6 Copayments, Coinsurance, and Deductibles. Your Copayment, Coinsurance, and Deductible amounts are listed in Your Schedule of Benefits, Covered Services, and Exclusions. You are responsible for paying Copayments to Your Provider at the time of service. Coinsurance and Deductible amounts, based on the Health Plan’s reimbursement to the Provider, may be due to the Provider before or at the time of service.

In-Network. When You receive In-Network Covered Services, You are responsible only for the applicable Copayment, Deductible, and/or Coinsurance amounts noted in Your Schedule of Benefits, Covered Services, and Exclusions. For the most up-to-date Provider information, you may contact the CHL Customer Service Department or access Our website at www.chcnevada.com.

Out-of-Network. Services rendered by Non-Participating Providers are not covered, except for the following:

- Emergency Services
- Urgent Care provided outside the Service Area
- Services Authorized in advance by CHL

If You receive Covered Services from a Non-Participating Provider, You are responsible for the
Copayment, Deductible, and/or Coinsurance amounts noted in Your Schedule of Benefits, Covered Services, and Exclusions, plus any amount in excess of the Out-of-Network Rate ("ONR"). Please see Section 1.8 for more information on the Out-of-Network Rate.

**Individual Deductible.** The Individual Deductible applies when only one Member is enrolled in Your Plan. For services subject to the Deductible, You must satisfy Your individual calendar year Deductible before the Health Plan will pay for Your Covered Services. After the individual annual Deductible is satisfied, the Health Plan will pay for Your Covered Services, minus any applicable Copayments or Coinsurance. Please refer to the Schedule of Benefits, Covered Services, and Exclusions for the details of Your Plan.

**Family Deductible.** The Family Deductible applies when two or more Members are enrolled in Your Plan. For services subject to the Deductible, You must satisfy Your family calendar year Deductible before the Health Plan will pay for Covered Services for any family Member. The Family Deductible is met by any combination of family Members meeting the total family Deductible amount. Please refer to the Schedule of Benefits, Covered Services, and Exclusions for the details of Your Plan.

We have contractual arrangements with Participating Providers and other health care Providers, Provider networks, pharmacy benefit managers, and other vendors of health care services and supplies ("Providers"). In accordance with these arrangements, certain Providers have agreed to Discounted Charges.

A “Discounted Charge” is the amount that a Provider has agreed to accept as payment in full for Covered Services. A "Discounted Charge" does not include pharmaceutical rebates or any other reductions, fees or credits a Provider may periodically give Us. We will retain those amounts that are not “Discounted Charges.” However, We have taken those into consideration in setting the fees charged to provide services under this Plan.

Claims under the Plan and any Deductible, Copayment, Coinsurance and benefit maximums as described in this Contract will be determined based on the Discounted Charge.

1.7 **Out-of-Pocket Maximum (OOP).** Your OOP amounts are listed in Your Schedule of Benefits, Covered Services, and Exclusions. The individual OOP applies when only one Member is enrolled in Your Plan. The family OOP applies when two or more Members are enrolled in Your Plan. The OOP amount is the total amount You must pay out of Your pocket annually for Covered Services.

1.8 **Payment to Providers.**

1.8.1 **In Network Providers (Participating Providers).**

For In-Network Covered Services, the Participating Provider will bill the Health Plan directly for the services. You do not have to file any claims for these services.

You are responsible for payment of:

A. The applicable In-Network Copayment, Deductible, and/or Coinsurance amounts;
B. Services that require Prior Authorization, which were not Prior Authorized;
C. Services that are not Medically Necessary; and
D. Services that are not Covered Services.

1.8.2 **Out of Network Providers (Non-Participating Providers).**

If You receive Covered Services from an Out-of-Network Provider, You should ask the Non-Participating Provider to bill Us directly. However, if the Provider asks You to pay for the services, make sure You receive an itemized bill that includes all of the following
information:

- Your name and CHL membership number
- The Provider’s name, address and telephone number
- An explanation of why you needed medical care, such as a description of symptoms or diagnoses (including medical records, if available)
- A list of treatments and supplies given, including the charges for each treatment and supply
- The date(s) on which services were received
- The place where services were provided, such as a doctor’s office, clinic, emergency room or a hospital room (inpatient)
- Proof of payment

If urgent or emergency care was received outside the United States, obtain a notation of the currency exchange rate for the date(s) of service and, if necessary, an English translation of the itemized bill.

Submit Your claim with all of the information above to Us no later than twelve (12) months from the date You received the services, or as soon as reasonably possible.

Send claims information to the following address:

Coventry Health and Life Insurance Company
Claims Department
P.O. Box 7801
London, KY 40742

We may deny Your claim if You or Your Provider submit it to us more than twelve (12) months after You received the services, unless you can show that the claim was submitted as soon as reasonably possible.

When we cover services from a Non-Participating Provider, We may pay benefits directly to you. When we pay benefits directly to You, we will send You an explanation with the payment stating that You are responsible to pay that amount to Your Provider.

Our payment for Covered Services from Non-Participating Providers is limited to the Out-of-Network Rate, less the applicable Copayment, Deductible, and/or Coinsurance amounts You are required to pay under Your Plan.

**Out-of-Network Rate (ONR).** The ONR is the Allowed Amount for charges billed by Non-Participating Providers. The ONR is based on a percentage of what Medicare would pay the same Provider for the same service.

If the amount You are billed by a Non-Participating Provider is equal to or less than the ONR amount, the charges should be completely Covered by Us, except for any Copayment, Deductible, and/or Coinsurance amounts You are required to pay under Your Plan. However, if the amount You are billed by the Out-of-Network Provider is greater than the ONR amount, You must pay the amount in excess of the ONR amount, in addition to Your Copayment, Deductible, and/or Coinsurance amounts.

**Please Remember**

If We cover services you receive from a Non-Participating Provider, You are responsible for paying the billed charges that exceed the ONR amount We allow, in addition to Your Copayment, Deductible, and/or Coinsurance amounts.

**This excess amount may be substantial.**
Here is an example of what Your costs could be using an In-Network Participating Provider under the scenario detailed below.

<table>
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<tr>
<th>IN-NETWORK RULES</th>
<th>IN-NETWORK AMOUNTS</th>
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<tbody>
<tr>
<td>(A) Total amount billed by the Participating Provider for a procedure:</td>
<td>$12,000</td>
</tr>
<tr>
<td>(B) Our Allowed Amount for the procedure, as indicated in the In-Network Provider’s contract with Us:</td>
<td>$10,000</td>
</tr>
<tr>
<td>Your In-Network Deductible:</td>
<td>$2,000</td>
</tr>
<tr>
<td>(C) We subtract Your Deductible from (B):</td>
<td>$10,000 - $2,000 = $8,000</td>
</tr>
<tr>
<td>Your In-Network Coinsurance:</td>
<td>30%</td>
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<tr>
<td>(D) We apply Your Coinsurance to (C):</td>
<td>30% of $8,000 = $2,400</td>
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Difference between (A) and (B):

PLEASE NOTE: Because We have a contract with the Participating Provider, You are not responsible for paying the difference between the total billed amount and the Allowed Amount.

$12,000 - $10,000 = $2,000 (You are not required to pay this amount)

Total amount We pay for procedure:

$10,000 (Our Allowed Amount)  
– $2,000 (Your Deductible)  
– $2,400 (Your Coinsurance)  
$5,600

Total amount You pay for procedure:

$2,000 (Your Deductible)  
+$2,400 (Your Coinsurance)  
$4,400

1.9 Premium Payment and Grace Period. The monthly Premium is due on the first (1st) day of each month. There is a thirty (30) day grace period for Premium payments. In other words, if the required Premium payment is not paid on or before the first (1st) day of the month (i.e., the due date), it may be paid during the grace period. Claims will be pended until the premium is received. If the Premium payment is not received by the end of the grace period, Your Coverage under the Contract will be terminated effective at 11:59 p.m. on the last date of the grace period. If Your Coverage is terminated for non-payment of Premium, please be aware that You will be responsible for the cost of any health care services You receive after the termination date.

1.10 Changes in Premium or Benefits. Your rates that begin on Your Member Effective Date will not change until January first (1st) of each year. Upon renewal and in accordance with applicable law, We may increase or decrease the Premium and/or Covered Services for all Members covered under an individual Contract in the event that any state or federal laws or regulations require Us to cover additional services, reduce Coinsurance or Deductibles, or otherwise expand Coverage in order to meet new minimum standards.

In the event of such change, We will send You a notice via U.S. mail at Your last known address. Any such change will take effect on the first (1st) of the month following approval from the Nevada Insurance Department, as necessary, following the required sixty (60) day period.

Renewals are effective on the first (1st) day of January each year. Any applicable age band
changes are included in the annual renewal.

1.11  **How to Contact the Health Plan.** Whenever You have a question or concern, please call Our Customer Service Department at the telephone number listed on Your Member ID card, or visit Our website at www.chcnevada.com. Our contact information is listed as follows.

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<td><strong>Address</strong></td>
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1.12  **Verification of Benefits.** When We provide information about which health care services are covered under Your Plan that information is referred to as verification of benefits. When You or Your Provider call Our Customer Service Department at 866-364-5663 during regular business hours to request verification of benefits, a Health Plan representative will be immediately available to provide assistance. If the health care services are verified as a covered benefit, the Customer Service representative will advise whether Prior Authorization is required.

Please be aware that verification of benefits is not a guarantee of payment for services.

### SECTION 2
**ENROLLMENT, ELIGIBILITY, AND EFFECTIVE DATES**

2.1  **Eligibility.**

2.1.1  **Subscriber Eligibility.** To be eligible to be enrolled as a Subscriber, You must meet all of the criteria listed below.

A. Be a Qualified Individual;
B. Live, work, or reside in the CHL Service Area;
C. Complete and submit to Us such Applications, Forms, or other documents that We may reasonably request.

2.1.2  **Dependent Eligibility.** To be eligible to be enrolled as a Dependent, an individual must be a Qualified Individual.
2.3 Persons Not Eligible to Enroll.
Any person that is determined not to be a Qualified Individual.

2.4 Enrollment and Effective Dates. The effective date will be a future first (1st) day of the month effective date, based on the date of receipt of a completed application and assigned by the Health Plan.

2.5 Notification of Change in Status. You must notify Us, in writing, of any changes in Your status or the status of any Dependent within thirty-one (31) days after the date of the status change. This notification must be submitted to Us in writing on a Change Form. Events that qualify as a change in status include, but are not limited to, changes in address, divorce, marriage, death, dependency status, incarceration, loss of legal residency in the United States, Medicare enrollment, or Coverage by another insurance policy. CHL requires notice of Medicare enrollment or Coverage by another payer for purposes of coordinating benefits. We should be notified within a reasonable time of the death of any Member. For more information, call Customer Service at 866-364-5663.

In the event of a divorce from Subscriber, the spouse/domestic partner of the Insured, if covered under Subscriber’s policy, shall be provided coverage most nearly similar to existing coverage, not subject to additional waiting periods or pre-existing condition limitations or Subscribers and without evidence of insurability, upon application to Us within thirty (30) days following eligibility and upon payment of the appropriate Premium.

2.6 If You Become Enrolled in Medicare While Covered Under CoventryOne®. Under the terms of this Contract, Medicare will pay primary, to the extent stated in federal law. As long as You continue to pay Premium to Us, You will remain enrolled in Your CoventryOne® Contract. Claims will be processed according to your Plan and will be coordinated with Medicare, when applicable.

SECTION 3
TERMINATION OF COVERAGE

3.1 Termination.

A. Termination by Subscriber.

The Subscriber may terminate Coverage for himself/herself and any enrolled Dependents under the Contract for any reason by providing thirty-one (31) days advance written notice to Us. Termination will take effect on the first day of the month following the request notification period. The notice of termination should be sent to:

CoventryOne®
Coventry Health and Life Insurance Company
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095-3918

If the Subscriber requests termination of a spouse/domestic partner Coverage for any reason other than divorce or annulment, We may require verification of the spouse/domestic partner consent for such termination.
B. Termination by Us.

1. We may terminate this Contract for all covered Members under the following conditions:

   a. In the event that We do not receive Your first (1st) Premium payment at the time of Application, Your Coverage under the Contract will be terminated.

   b. In the event that We do not receive payment of Premium, other than the first (1st) month’s Premium, by the end of the thirty (30) day grace period, Your Coverage under the Contract will be terminated at 11:59 p.m. on the last of the grace period. If Your Coverage is terminated for non-payment of the Premium, You will be responsible for the cost of any health care services You receive after the termination date.

   c. Neither the Subscriber nor the Subscriber’s covered spouse/domestic partner lives, works, or resides in the CHL Service Area;

   d. We elect to discontinue offering the CoventryOne® Select Network HMO product. If termination occurs for this reason, We will notify You ninety (90) days prior to termination and You will have the option to purchase, on a guaranteed issue basis, all other individual health benefit products We offer in the individual market; or

   e. We cease to offer Coverage in the individual market in accordance with applicable state and federal law. If termination occurs for this reason, We will notify You one-hundred eighty (180) days prior to termination.

2. We may terminate a Member’s Coverage under this Contract in any of the following situations:

   a. Coverage will be terminated immediately if a Member has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the Coverage in connection with enrollment, in connection with obtaining or requesting Covered Services, or in the use of Participating Providers, facilities, or services. This includes knowingly permitting the use of Your Member ID card by any other person or using Your Member ID card to obtain care or services for which You are not eligible under this Contract. If termination under this provision has a retroactive effect, such termination will not become final until the Member has been provided with sixty (60) days written notice; or

   b. Loss of eligibility as a Dependent of the Subscriber. A Subscriber’s child shall become ineligible upon attainment of age twenty-six (26) as specified in this Contract, or as otherwise specified herein. A Subscriber’s spouse/domestic partner shall become ineligible upon the termination of marriage/domestic partnership to the Subscriber. Coverage shall remain in effect through the end of the month in which eligibility ends. If We are not notified of the loss of eligibility within thirty-one (31) days after such loss occurs, We at Our option may choose to terminate Coverage at the end of the month in which We become aware that a child or former spouse/domestic partner is no longer an eligible Dependent. Premiums must be paid until the Coverage termination date.
If a Dependent loses coverage due to attainment of age twenty-six (26), death of the Subscriber, or divorce, the Dependent is entitled to be issued an individual or family Contract that provides Coverage similar to the Coverage provided under this Contract. Upon application made to Us within thirty-one (31) days following the terminating event, and upon payment of the appropriate Premium, We will issue the Dependent or Dependents an individual or family Contract.

3.2 Reinstatement. If any renewal Premium is not paid within the time granted the insured for payment, a subsequent acceptance of Premium by the insurer or by any agent duly authorized by the insurer to accept the Premium, without also requiring an application for reinstatement, shall reinstate the Contract. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Contract shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the forty-fifth (45th) day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The insured and insurer have the same rights under the reinstated Contract as they had under the Contract immediately before the due date of the defaulted Premium, subject to any provisions endorsed on or attached to this Contract in connection with the reinstatement.

3.3 Renewal. Renewals occur on the first (1st) day of January, each year. Your Plan is renewable as long as Premiums are paid, You and Your Dependents continue to meet eligibility requirements, and the Subscriber continues to live, work, or reside in the CHL Service Area. We will not change Your Premium because of claims filed or due to a change in Your health since becoming a Member. Renewal Premiums are based on age, area of residence, family size, tobacco use, and the type of Plan You have.

3.4 Effect of Termination. If Your Coverage under the Contract terminates, all rights to receive Covered Services shall cease as of 11:59 p.m. on the date of termination.

Your Coverage shall not be terminated on the basis of Your health status or the exercise of Your rights under Our complaint procedures.

Termination will be without prejudice to any claim originating prior to the effective date of termination.

3.5 Certificate of Creditable Coverage. At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any creditable Coverage began and ended.

A certificate of creditable Coverage under this Contract will be issued:

A. When a Subscriber or Dependent ceases to be Covered under this Contract for any reason, or

B. When requested by a Subscriber or Dependent within twenty-four (24) months of the termination of Coverage.

SECTION 4
CLAIMS FOR REIMBURSEMENT OF SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

4.1 Notice of Claim and Timely Submission of Claim. Participating Providers are responsible for submitting claims directly to Us for Covered Services provided to Members. However, when You receive Covered Services from a Non-Participating Provider, You or the Non-Participating Provider must provide Us written notice of the claim within twelve (12) months of the date of service, or as soon as reasonably possible. Such services must have been provided in
accordance with Our Utilization Management Program and Prior Authorization policies and procedures. Claims are denied if submitted to us more than one year after services were rendered, unless You can show that notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims are denied if submitted to us more than one (1) year after claims were first processed, unless You can show that the additional information relating to the claim was filed as soon as reasonably possible. Send claims to:

Coventry Health and Life Insurance Company
Claims Department
P.O. Box 7801
London, KY 40742

SECTION 5
COVERED SERVICES

5.1 Covered Services.

PLEASE SEE THE SCHEDULE OF BENEFITS, COVERED SERVICES, AND EXCLUSIONS FOR A LIST OF HEALTH CARE SERVICES AND SUPPLIES COVERED UNDER YOUR CONTRACT.

Under this PPO Plan, inpatient, outpatient, and other Covered Services are available through both In-Network (Participating) Providers and Out-of-Network (Non-Participating) Providers. However, certain services are covered only when you use Participating Providers. Refer to the Schedule of Benefits, Covered Services, and Exclusions for details. Benefits under this Plan are subject to Our Utilization Management Program. Please be aware that Coverage may be denied if the Covered Services You receive are not compliant with the Utilization Management Program. See Section 1.3 for more information on Our Utilization Management Program.

Keep in mind that using a Participating Provider (Your In-Network benefits) will usually cost You less than using a Non-Participating Provider (Your Out-of-Network benefits). This is because Participating Providers are contracted with Us to provide health care services to Members for a lower fee, whereas Non-Participating Providers are not contracted with Us. Please see Section 1 for more information on how Your In-Network and Out-of-Network benefits work.

Please note that the Health Plan covers only those health care services and supplies that are:

(1) deemed Medically Necessary,
(2) provided by a Participating Provider, except in emergency situations,
(3) Authorized, if Authorization is required,
(4) listed as a Covered Service in the Contract and not excluded under the Contract, and
(5) incurred while the Member is eligible for Coverage under the Contract.

See Section 1.3. Prior Authorization is required for some services. It is advised that either You or Your Provider call Customer Service for clarification if there are any concerns. Benefits may be subject to other limitations, as outlined in this document or affiliated schedules and riders.

SECTION 6
EXCLUSIONS AND LIMITATIONS

6.1 PLEASE SEE THE SCHEDULE OF BENEFITS, COVERED SERVICES, AND EXCLUSIONS FOR A LIST OF HEALTH CARE SERVICES AND SUPPLIES THAT ARE LIMITED OR
EXCLUDED FROM COVERAGE UNDER YOUR CONTRACT.

SECTION 7
COMPLAINTS AND APPEALS

7.1 Complaint Resolution.
We maintain both informal and formal procedures to resolve Insured Inquiries, Complaints, and Appeals. These processes give Insureds the opportunity to ask Us to review any matter related to Covered Services, including but not limited to:

- Issues about the scope of Coverage for health care services;
- Denial, cancellation, or Non-Renewal of Coverage;
- Denial of care/services/claims;
- Insured rights; and
- The quality of the health care service received.

7.1.1 Procedure for Filing an Inquiry, Complaint or Appeal

Investigation Upon Receipt of a Complaint or Inquiry by Telephone: If You have a Complaint or Inquiry, You may submit it telephonically at 866-364-5663. When this is done, the Customer Services representative will make every effort to resolve the issue within one (1) working day. In some cases, however, it may take as long as fifteen (15) working days or more from the date of the call for resolution. If You are not satisfied with the resolution of Your Complaint or Inquiry and You would like the Health Plan to conduct any further review, You must submit the Complaint or Inquiry to the Health Plan in writing.

Written Inquiries: You may submit a written Inquiry to the Customer Services Department. You will be sent an acknowledgement letter within five (5) working days of the original receipt of the Inquiry. When this is done, you will receive resolution of the Inquiry within thirty (30) calendar days.

Written Complaints (Grievances): You may submit a written Complaint, also known as a Grievance, to the Member Services Department. A Grievance that involves an Adverse Benefit Determination will be treated as an Appeal; please refer to the Appeals section below. For Grievances that do not involve an Adverse Benefit Determination, You will be sent an acknowledgement letter within five (5) working days of the original receipt of the Grievance. We will complete Our investigation and notify You and Your Authorized Representative of Our determination within thirty (30) calendar days from the date the Grievance is filed, unless You have agreed to a longer time period.

7.1.2 Appeals

Notice of Appeal: If You wish to submit an Appeal of an Adverse Benefit Determination, You should contact the Appeals and Grievances Department in writing. If You prefer, You may also request information by contacting Member Services telephonically at 866-364-5663. However, a formal Appeal must be submitted in writing within 180 days of an Adverse Benefit Determination and must include the following information:

- Insured name;
- Provider name;
- Date(s) of service;
- Insured’s and/or Insured’s Authorized Representative’s mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should “reverse” the Adverse Benefit
Determination;

- Copy of documentation to support the reversal of decision, e.g. Emergency details, date, time, symptoms, why the Insured did not contact the PCP, etc.; and

- In cases where the Insured’s Authorized Representative is appealing on behalf of the Insured, a completed Member Designated Release of Information form, which can be obtained by calling the Member Services Department.

Written appeals must be sent to the following address:

Coventry Health Care
Appeals and Grievance Department
10421 South Jordan Gateway, #400
South Jordan, UT 84095

You may ask the Health Plan to appoint a staff member to assist You or Your Authorized Representative with the Appeal at any time during the process. The Appeals and Grievances Department will investigate the issue and submit the Appeal with all relevant information to a review board for determination. Any new or additional information or rationale considered in review of the appeal will be given to you as soon as possible, to allow you to respond prior to the date the review board’s final decision is due. The review board members will have no prior involvement in the case and will not be subordinates of the individual who rendered the Adverse Benefit Determination. For Appeals based in whole or in part on medical judgment, the committee will include a Physician. If necessary, the committee will consult a health care professional, or professionals, who have appropriate training and experience in the field of medicine related to the subject of the Adverse Benefit Determination.

The Insured or Authorized Representative will be notified in advance of the place, date and time of the review board meeting and of the right to receive, free of charge, reasonable access to and copies of documentation relevant to the Appeal. Any supporting material may be submitted before and at the meeting. The Insured may also appear before the review board to present testimony concerning the Appeal, or be represented by a person of his or her choice.

Appeals are concluded as follows:

1. Urgent Care Appeals

   For Appeals satisfying the definition of an Urgent Care Appeal you may request an expedited Appeal of a Health Plan decision verbally or in writing. The Insured may also request an expedited external review for an Experimental/Investigational determination at the same time as an expedited Urgent Care Appeal to the Health Plan if the treating Physician certifies in writing that the service or treatment would be less effective if not promptly initiated. The Independent Review Organization will then determine if the Health Plan’s internal review must be completed before conducting the expedited external review. Urgent Care Appeals will be completed within seventy-two (72) hours after receipt of the Appeal request. We will notify Insureds and/or Authorized Representatives verbally and provide a follow-up written notice within seventy-two (72) hours after receipt of the Appeal request.
2. **Pre- and Post-Service Appeals**

Requests for Pre- and Post-Service Appeals will be acknowledged by letter within five (5) working days of receipt of the Appeal request. We will complete Our investigation and notify Insureds and/or Authorized Representatives within thirty (30) calendar days of receipt of the Appeal request; however, with the Insured’s permission, We may delay the resolution of the Appeal for thirty (30) calendar days if We have not received adequate information.

Our written notification to the Insured or Authorized Representative will provide the reason for the decision. The written notice will also include information on applicable review processes available under state law.

7.2 **Procedure for Filing an External Review**

7.2.1 **Experimental/Investigational Determination**

**Standard Review:** In the event that an Appeal of an Adverse Benefit Determination is based on the decision that the requested health care service or supply is Experimental or Investigational, and the Insured is not satisfied with the outcome of the Appeal review process as explained in this section of the Certificate, the Insured has the right, but not the obligation, to submit the Appeal to external review. External review Appeals are conducted by independent review organizations (IROs) selected by the Nevada Office for Consumer Health Assistance (OCHA). Except when agreed upon by both parties, or when we fail to follow the established appeals procedure as described above, the internal review process must be exhausted before an Appeal can be submitted for external review. The Insured may also request an expedited external review at the same time as an expedited ‘Urgent Care Appeal’ to the Health Plan if the treating Physician certifies in writing that the service or treatment would be less effective if not promptly initiated. The IRO will then determine if the Health Plan’s internal review must be completed before conducting the expedited external review.

The Health Plan will pay for the costs of the external review, including filing, administrative, and reviewer fees. Any statute of limitations or other defense based on timeliness will not be counted during the time that an external review is pending.

All requests for external review must be made within four (4) months from the date the Adverse Benefit Determination is received. To request an external review, the Insured, treating Physician, or Insured’s representative must complete and submit on the appropriate forms a request for external review of the Adverse Benefit Determination to OCHA. The Insured must also complete an authorization form allowing the Health Plan and the treating Physician/health care providers to disclose the Insured’s protected health information (PHI), including medical records, which are pertinent to the external review.

OCHA will notify the Health Plan within one (1) business day of the request for an external review. The Health Plan will review the request to determine if it is eligible for external review and make a preliminary determination within five (5) business days of notification. The Health Plan will notify the Insured or the Insured’s representative, if applicable, and OCHA within one (1) business day of completion of the preliminary determination that the request is: a) complete; b) eligible for external review; c) incomplete, with a notice of what additional information is necessary; or d) not eligible for external review. If the Health Plan determines the request is not eligible, the Insured may Appeal the decision to OCHA.

When a determination is made that the request is eligible for external review, OCHA will select an IRO within one (1) business day of the decision and notify the Insured and the Health Plan of the assignment. The Health Plan will provide the IRO with all relevant documents and information it used in making the Adverse Benefit Determination within five (5) business days of the IRO selection notice. The Insured, treating Physician, or Insured’s representative may also provide the IRO and the Health Plan with any additional information that is relevant to the review.
information within five (5) business days after the selection of the IRO. Information received after that time may be considered as well. The Health Plan may review and reverse the Adverse Benefit Determination based on the new information before the IRO makes a determination.

Within one (1) business day of its selection notice, the IRO will select clinical reviewers who are experts in the treatment of the Insured’s condition and knowledgeable about the recommended or requested health are service or treatment to review the submitted information. The clinical reviewer(s) must return their written opinion within twenty (20) calendar days of being selected. The IRO must make written notice of its decision to the Insured, treating Physician, Insured’s representative, and the Health Plan within twenty (20) calendar days of its receipt of the opinion(s) from the clinical reviewer(s).

Expedited Review: The Insured or Insured’s representative may make a written or oral request for an expedited external review of an Adverse Benefit Determination to OCHA if the timeframe for completion of an external review would seriously jeopardize the life or health of the Insured's ability to regain maximum function. The Insured or Insured's representative must submit written certification from the Insured’s Physician that failure to proceed in an expedited manner would be significantly less effective if not promptly initiated. OCHA will immediately notify the Health Plan of the request. The Health Plan will immediately determine if the request is eligible for an expedited external review and notify OCHA and the Insured, or Insured's representative, if applicable. If the Health Plan determines the request is not eligible, the Insured may appeal the decision to OCHA.

When a determination is made that the request is eligible for expedited external review, OCHA will immediately select an IRO and notify the Health Plan and the Insured, or Insured’s representative, if applicable. The Health Plan will immediately provide the IRO with all relevant documents and information it used in making the Adverse Benefit Determination. The IRO will select clinical reviewers who are experts in the treatment of Your condition and knowledgeable about the recommended or requested health care service or treatment to review the submitted information. The clinical reviewer(s) must return their opinion within five (5) calendar days of being selected. The IRO must make written notice of its decision to the Insured, treating Physician, Insured’s representative, and the Health Plan within forty-eight (48) hours of its receipt of the opinion(s) from the clinical reviewer(s). If the determination of the IRO concerning an expedited external review is in favor of the Insured, the Health Plan will consider the determination to be final, conclusive and binding upon itself, and will immediately approve the coverage or recommended treatment.

7.2.2 Medical Necessity Determination

Standard Review: In the event that an Appeal of an Adverse Benefit Determination is based in whole or in part on Medical Necessity, and the Insured is not satisfied with the outcome of the Appeal review process as explained in this section of the Certificate, the Insured has the right, but not the obligation, to submit the Appeal to external review. External review Appeals are conducted by independent review organizations (IROs), selected by the Nevada Office for Consumer Health Assistance (OCHA). Except when agreed upon by both parties, or when we fail to follow the established appeals procedure as described above, the internal review process must be exhausted before an Appeal can be submitted for external review. The Health Plan will pay for the costs of the external review, including filing, administrative, and reviewer fees. Any statute of limitations or other defense based on timeliness will not be counted during the time that an external review is pending.

All requests for external review must be made within four (4) months from the date the Adverse Benefit Determination is received. To request an external review, the Insured, treating Physician, or Insured’s representative must complete and submit on the appropriate forms a request for external review of the Adverse Benefit Determination to

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OCHA. The Insured or Insured’s representative must also complete an authorization form allowing the Health Plan and the treating Physician/health care providers to disclose the Insured’s protected health information (PHI), including medical records, which are pertinent to the external review.

Within five (5) business days after receiving a request for external review, OCHA will notify the Insured, treating Physician, Insured’s representative, and the Health Plan that the request has been filed with OCHA. OCHA will assign an IRO to conduct the review.

Within five (5) business days after receiving notification from OCHA specifying the designated IRO, the Health Plan will forward all relevant information to the IRO. Within five (5) calendar days after receiving information from the Health Plan, the IRO may request additional information as necessary. Information requested from the Insured must be provided within five (5) calendar days after receiving notice that it is required to conduct the review. The IRO must submit any additional information received to the Health Plan within one (1) business day of its receipt. Once all required information is received, the IRO will make a determination within fifteen (15) calendar days and provide written notification of its determination to the Insured, treating Physician, Insured’s representative, and the Health Plan.

**Expedited Review:** The Insured or Insured’s representative may make a written or oral request for an expedited external review of an Adverse Benefit Determination to OCHA, which will approve or deny a request for external review no later than seventy-two (72) hours after receiving proof from the Insured’s Physician that:

1. The Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which the Insured received emergency services but has not been discharged from the facility providing the services or care; or
2. Failure to proceed in an expedited manner may jeopardize the life or health of the Insured, or the ability to regain maximum function.

If OCHA approves the request for an expedited external review, OCHA will assign the request to an IRO within one (1) working day. The Health Plan will provide the IRO with all relevant documents and information it used in making the Adverse Benefit Determination within twenty-four (24) hours of the selection.

The IRO will complete the expedited external review within forty-eight (48) hours after receiving the assignment, unless the Insured and Health Plan agree to an extension. The IRO will provide notification of its determination to the Insured, treating Physician, Insured’s representative, and the Health Plan, according to the following timeframes:

1. By telephone no later than twenty-four (24) hours after completing its review; and
2. In writing no later than forty-eight (48) hours after completing its review.

If the determination of the IRO concerning an external review of an Adverse Benefit Determination is in favor of the Insured, the Plan will consider the determination to be final, conclusive and binding upon itself.
7.3 Office for Consumer Health Assistance

You may contact the Nevada Office for Consumer Health Assistance at the following address, telephone numbers or e-mail address:

Governor’s Office for Consumer Health Assistance
555 E. Washington Ave., Suite 4800
Las Vegas, NV 89101

Hours: Monday – Friday 8:00 am to 5:00 pm
Phone: (702) 486-3587 or Toll Free 1-888-333-1597
Fax: (702) 486-3586
Email: cha@govcha.state.nv.us

SECTION 8
CONFIDENTIALITY OF YOUR HEALTH INFORMATION

We work hard to keep Your personal health information secure and private. You will receive a copy of Our Notice of Privacy Practices upon Your enrollment. This notice fully explains how We may use and share Your information. The notice is posted on Our web site at www.chcnevada.com, and You can also request another copy by calling Customer Service at 866-364-5663. In general, We can access and disclose Your records and medical information as permitted under the privacy regulations set forth at 45 C.F.R. Part 164 and promulgated pursuant to the Federal Health Insurance Portability and Accountability Act of 1996.

Genetic Testing. In the event that We receive information derived from genetic testing that You have undergone, We agree not to use this information for any non-therapeutic purpose. We further agree not to release this information to any third party without Your explicit written consent.

SECTION 9
COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when a Member has health care Coverage under more than one plan. “Plan” is defined below. The order of benefit determination rules described herein determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed one hundred percent (100%) of the total Allowable Expense.

9.1 Definitions. In addition to the Definitions section of this Contract, the following definitions apply to Coordination of Benefits.

A. “Allowable Expense” means any health care expense, including Coinsurance or Copayments and without reduction for any applicable Deductible, that is covered in full or in part by any of the plans covering the Member. Allowable expense does not include outpatient Prescription Drugs that are typically self-administered or obtained through a pharmacy. An expense or portion of an expense that is not covered by any of the plans is not an allowable expense. Any expense that a Provider, by law or in accordance with a contractual agreement, is prohibited from charging a Member is not an allowable expense. Any expense that a
Provider, by law or in accordance with a contractual agreement, is prohibited from charging a Member is not an allowable expense.

The following are examples of expenses or services that are not Allowable Expenses:

If a Member is confined in a private Hospital room, the difference between the cost of semi-private accommodations in the Hospital and the private room (unless the Member’s stay in a private Hospital room is otherwise a covered benefit).

If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees.

If a Member is covered by two or more plans that compute benefit payments on the basis of usual and customary fees, or similar reimbursement methodology, charges in excess of the highest reimbursement amount.

B. “Birthday” refers only to the month and day in a calendar year and does not include the year in which the person was born.

C. “Closed Panel Plan” is a plan that provides health benefits to covered Members primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

D. “Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

E. “Plan” means any of the following that provides Coverage for medical, pharmacy, or dental services:

“Plan” includes: individual or family insurance; closed panel or other individual Coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.

“Plan” does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage; benefits provided in long-term care insurance policies for non-medical services; Medicare supplement policies, a state plan under Medicaid; or a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

9.2 Order of Benefit Determination. When two or more plans pay benefits, the Primary Plan pays or provides its benefits as if the Secondary Plan or plans did not exist. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan. Each plan determines its order of benefits using the first of the following rules that applies:

A. Non-Dependent or Dependent. The plan that covers the Member other than as a dependent is the Primary Plan, and the plan that covers the Member as a dependent is the Secondary Plan.

B. For a child whose parents are married or living together, if they have never been married:

1. The plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan;
2. If both parents have the same birthday, the plan that has covered a parent longest is the Primary Plan;

C. For a child whose parents are divorced or separated, or are not living together if they have never been married:

1. If a court decree states that one of the parents is responsible for the child’s health care expenses or health care coverage, the responsible parent’s plan is primary. If the parent with responsibility has no health care coverage for the child’s health care expenses, but that parent’s spouse does, the spouse’s plan is primary.

2. If a court decree states that both parents are responsible for the child’s health care expenses or health care coverage, the rules outlined in paragraph B. shall apply.

3. If a court decree states that the parents have joint custody without stating that one parent has responsibility for the child’s health care expenses or health care coverage, the rules outlined in paragraph B. shall apply.

4. If there is no decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child is as follows:
   a. The plan covering the custodial parent;
   b. The plan covering the custodial parent’s spouse;
   c. The plan covering the non-custodial parent; and then
   d. The plan covering the non-custodial parent’s spouse.

D. When a child is covered by one or more plans that provide coverage for individuals who are not the child’s parents, such as guardians, the order of benefits shall be determined under paragraph B. or C., as if those individuals were parents of the child.

E. Active, Retired, or Laid-off Employee. The plan that covers a Member as an active employee who is neither laid off, nor retired, nor a dependent of an active employee, is the Primary Plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the Secondary Plan. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.

F. COBRA or State Continuation Coverage. Coverage provided to a Member under COBRA or a right of continuation under state or other federal law is secondary to other plans providing coverage to the Member. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.

G. Longer or Shorter Length of Coverage. If the preceding rules do not determine the order of benefits, the plan that has covered the Member for the longer period of time is the Primary Plan and the plan that has covered the Member for the shorter period of time is the Secondary Plan.

H. If none of the above rules determine the Primary Plan, or if the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all information needed to pay a claim, the allowable expenses shall be shared equally between the plans; however, CHL will not pay more than it would have paid if this Contract had been the Primary Plan.

9.3 Primary Plan Benefits. When this Contract is the Primary Plan, CHL will pay benefits as if no other health plan exists. Despite the requirement in Section 4.1 of this Contract, we will not deny payment of a benefit on the grounds that a claim was not timely submitted if the claim was timely submitted (within the twelve (12) month period), to one or more
secondary plans and was submitted to the primary plan within thirty-six (36) months of the date of service.

9.4 **Secondary Plan Benefits.** This provision applies when this Contract is a Secondary Plan.

If this Contract is a Secondary Plan, CHL will calculate the amount of benefits that it would normally pay in the absence of the Primary Plan and apply that payable amount to any allowable expense that is unpaid by the Primary Plan. Deductibles, Coinsurance and Copayments under this Contract will be used in the calculation of the benefits. CHL will credit to the Deductible under this Contract any amounts that would have been credited to the Deductible in the absence of other Coverage. Nothing contained in this COB provision is intended to require a Secondary Plan to make payment for all or part of any service that is not covered under the plan. In the event that CHL, as secondary, authorizes services from a Non-Participating Provider, and if the Primary Plan denies the services, CHL will base its payment on the Allowable Amount. The Member will be responsible to pay the difference between the Allowable Amount, as specified by CHL, and the Provider’s actual billed charges, in addition to any Copayment, Coinsurance, and/or Deductible.

If a Member is covered by a Primary Plan that calculates benefits on the basis of usual and customary fees, and this Contract provides benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with CHL to provide the service for a specific negotiated fee or payment that is different than the Primary Plan’s payment arrangement and if the Provider’s contract permits, that negotiated fee or payment shall be the allowable expense used by CHL to determine its benefits.

If this Contract is the Secondary Plan according to the Order of Benefit Determination and the other plan claims to be “always secondary” or uses order of benefit determination rules inconsistent with those above, this Plan shall pay its benefits first, but the amount paid shall be calculated as if this Plan is a secondary plan. The other plan or the Member needs to provide CHL with the information necessary for CHL to determine secondary benefits within a reasonable time. CHL shall assume its benefits are identical to the Primary Plan’s and pay secondary plan benefits accordingly, subject to adjustment upon receipt of the information requested from the Member.

If this Plan is a Secondary Plan according to the Order of Benefit Determination, prior authorization is required for all services listed in Section 1.3 of this Contract.

9.5 **No Expansion of Benefits.** In no event shall this Coordination of Benefits provision operate to increase the total benefits that would be provided under the Contract in the absence of this provision.

9.6 **Recovery of Overpayments.** If CHL pays more than it should have paid under the COB provisions, CHL will recover the excess as follows:

A. From the Member, if the Member was paid. Reversal of payments made due to issues related to coordination of benefits is limited to a time period of twenty-four (24) months from the date of payment, unless the reversal is due to fraudulent acts, fraudulent statements, or material misrepresentation by the Member. CHL is entitled to recover the amount of such excess by the reversal of payment from the Member, and the Member agrees to reimburse CHL on demand for any excess amount. In the event that CHL uses a third party collection agency or attorney to collect the overpayment, the Member agrees to pay collection fees incurred, including but not limited to any court cost or attorney fees. In the event that the Member does not
make payment to CHL, CHL may withhold future benefits to offset the amount owed to CHL.

B. From Providers CHL has paid. Reversal of payments made due to issues related to coordination of benefits will be limited to a time period of twenty-four (24) months from the date of payment, unless the reversal is due to fraudulent acts, fraudulent statements, or material misrepresentation by the Member. It is CHL’ responsibility to see that the proper adjustments between insurers and Providers are made;

C. From the other plan or insurer; or

D. From other organizations.

9.7 Information. For purposes of administering this Coordination of Benefits section, CHL may, without the consent of any person, release to or obtain from any insurance company, organization or person any information that CHL deems to be necessary. Any person seeking benefits under this Plan shall furnish CHL information necessary to administer this COB section of the Contract. Receipt of such information by CHL is required before CHL will provide benefits under this Plan.
SECTION 10
GENERAL PROVISIONS

10.1  Applicability.
The provisions of this Contract shall apply equally to the Subscriber and Dependents. All benefits and privileges made available to You shall be available to Your Dependents.

10.2  Choice of Law.
This Contract will be administered under the laws of the State of Nevada. Any provision of this Contract that is not in conformity with applicable law or regulation in the State of Nevada shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of the State of Nevada.

10.3  Discounts and Rebates.
As a Member of this Plan, You understand and agree that this Plan may receive a retrospective discount or rebate from a Participating Provider or vendor, related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by Members enrolled in health care Plans offered or administered by CHL and its affiliates. Though Members shall not share in such retrospective volume-based discounts or rebates, such aggregated rebates will be considered in Our prospective Premium calculations.

10.4  Entire Agreement.
This Contract shall constitute the entire agreement between the parties. This Contract is comprised of this Individual Member Contract; Schedule of Benefits, Covered Services, and Exclusions; Application Form; applicable riders; and amendments.

10.5  Exhaustion of Administrative Remedies.
You may not bring a cause of action hereunder in a court or other governmental tribunal, unless and until all administrative remedies set forth in this Contract have first been exhausted.

10.6  Misstatements.
Statements and descriptions in any application for an insurance policy during negotiations for such policy by or on behalf of the insured shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or Contract, unless they are fraudulent or material to the acceptance of the risk by the insurer, the hazard assumed by the insurer, or the insurer in good faith would either not have issued the policy or Contract in as large an amount or at the Premium rate as applied for or would not have provided Coverage with respect to the hazard resulting in the loss if the true facts had been known to the insurer as required either by the application for the policy or Contract or otherwise.

10.7  Nontransferable.
No person other than You is entitled to receive Coverage for health care services or other benefits to be furnished by Us under this Contract. Such right to Covered health care services or other benefits is not transferable.

10.8  Policies and Procedures.
We may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of this Agreement.

10.9  Relationship Among Parties Affected by Contract.
The relationship between CHL and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of CHL, nor is CHL or any employee of CHL an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.
10.10 Reservations and Alternatives.
We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

10.11 Severability.
In the event that any provision of this Contract is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Contract, which shall continue in full force and effect in accordance with its remaining terms.

10.12 Valid Amendment.
No change in this Contract shall be valid, unless approved by an officer of CHL and evidenced by endorsement on this Contract and/or by amendment to this Contract and agreed to, in writing, by You, as required in accordance with regulations promulgated according to the State of Nevada and federal guidelines. Such amendment will be incorporated into this Contract.

10.13 Waiver.
The failure of CHL or You to enforce any provision of this Contract shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Contract shall not be deemed or construed to be a waiver of such default.

SECTION 11
DEFINITIONS

Any capitalized terms listed in this section shall have the meaning set forth below whenever the capitalized term is used in this Contract.

11.1 Adverse Benefit Determination.
Any of the following: a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit, including a determination based on (a) a Subscriber's or Dependent's eligibility to participate in a plan, (b) the application of any utilization review, (c) failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate, (d) a rescission of Coverage or any other cancellation or discontinuance of Coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required Premiums or contributions toward cost of Coverage, or (e) a decision to deny Coverage in an eligibility determination.

11.2 Allowed Amount.
Maximum amount on which payment is based for Covered health care services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” If Your Non-Participating Provider charges more than the Allowed Amount, You may have to pay the difference.

11.3 Appeal.
A request for Your health insurer or Health Plan to review a decision or a Grievance again.

11.4 Authorization, Authorize or Prior Authorization.
A decision by Us that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary and covered under your Plan. We may require Authorization for certain services before You receive them, except in an emergency. Prior Authorization does not guarantee payment. We will not pay if You are not eligible for Covered Services at the time the service is provided.

11.5 Autism Spectrum Disorder.
A neurobiological medical condition including, without limitation, autistic disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

11.6 **Coinsurance.**
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the Allowed Amount for the service. You pay Coinsurance plus any Deductibles You owe. For example, if Our Allowed Amount for an office visit is $100 and You have met Your Deductible, Your Coinsurance payment of 20% would be $20. We pay the rest of the Allowed Amount.

11.7 **Complications of Pregnancy.**
Diseases or conditions which are distinct from pregnancy, but are adversely affected or caused by pregnancy, and not associated with a normal pregnancy. Such diseases or conditions require separate and specific medical or surgical services for which separate and additional charges are incurred. Complications of Pregnancy include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia.

This definition does not include false labor, occasional spotting, doctor-prescribed rest during the period of pregnancy, morning sickness, or conditions of comparable severity associated with management of a difficult pregnancy, including cesarean section delivery.

11.8 **Contract.**
The Individual Member Contract, Schedule of Benefits, Covered Services, and Exclusions, and all applicable riders, amendments, and endorsements together form the Contract.

11.9 **Copayment.**
Other than Coinsurance, a fixed amount (for example, $15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service, device, supply and/or drug. If the Allowed Amount for the Covered Service or Covered Drug is less than Your Copayment, you will pay the Allowed Amount.

11.10 **Cosmetic Surgery or Reconstructive Surgery.**
Any surgical procedure performed primarily to improve physical appearance. This definition does not include surgery that is necessary:

- to correct damage caused by injury or sickness;
- for reconstructive treatment following medically necessary surgery;
- to provide or restore normal bodily function; or
- to correct a congenital disorder that has resulted in a functional defect.

11.11 **Coventry Transplant Network Facility.**
A Provider or facility designated by Us to provide transplant services and treatment to Members.

11.12 **Covered Drug**
The Prescription Drugs and Self-Administered Injectable Drugs and Specialty Drugs that are prescribed by a Prescribing Provider, included on Our current Formulary, approved by Us and not otherwise excluded from Coverage in this Contract. A list of Covered Drugs can be found on Our website, along with criteria for their approval. Some Covered Drugs may not be authorized for Coverage as a treatment for Your diagnosis.

11.13 **Covered Services or Coverage.**
The services and supplies provided to You for which CHL will make payment, as described in the Contract.

11.14 **Customer Service and Customer Service Department.**
Our Customer Service Department is available to answer any questions or concerns You may
have about Your Coverage or Our policies or procedures, including, but not limited to, verification of benefits, Prior Authorization requirements, coordination of benefits information, and procedures for filing an Appeal. You may reach Our Customer Service Department at the telephone number on Your Member ID card.

11.15 Deductible.
The amount You are responsible to pay out-of-pocket each calendar year before We begin to pay the costs or provide the services described in this Contract. For example, if Your Deductible is $1,000, Your Plan will not pay anything until You have met Your $1,000 Deductible for Covered Services subject to the Deductible. The Deductible does not apply to all services.

11.16 Dependent.
Any member of a Subscriber’s family, who meets the eligibility requirements as outlined in this Contract.

11.17 Directory of Health Care Providers.
A paper or electronic listing of Participating Providers. Please be aware the information in the directory is subject to change.

11.18 Durable Medical Equipment (DME).
Equipment and supplies ordered for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

- Please see the Schedule of Benefits, Covered Services, and Exclusions for the specifics of Your Coverage.

11.19 Emergency Medical Condition.
A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient’s health, or if the patient is pregnant, the health of the patient’s unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

11.20 Emergency Room Care.
Emergency Services received in an emergency room.

11.21 Emergency Services.
Health care services that are provided for an Emergency Medical Condition.

11.22 Excluded Services.
Health care services that We do not pay for or provide Coverage for.

11.23 Experimental or Investigational.
A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing Prescription Drugs for treatments other than those stated in the labeling approved by the FDA;
• Any health product or service that is subject to review and approval by the Investigational Review Board (IRB) of the treating facility for the proposed use;

• Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, subject to the Schedule of Benefits, Covered Services, and Exclusions;

• Any health product or service whose effectiveness is determined to be unproven based on clinical evidence reported in prevailing, peer-reviewed medical literature, including literature reviewed by technology review organizations and literature reviewed against applicable policy statements promulgated by the government and/or professional medical organizations.

11.24 Formulary.
A listing of specific generic and brand name Prescription Drugs which are approved by Us and will be dispensed to You through a Participating Pharmacy. This listing is subject to periodic review and modification by Us at Our discretion. The Formulary is available for review on Our website, or by contacting our Customer Service Department.

11.25 Free Standing Facility
A facility not affiliated with a Hospital.

11.26 Grievance.
A written complaint submitted by or on behalf of a Member, in accordance with the CHL formal Grievance procedure, regarding any aspect of the CHL Plan, relative to the Member.

11.27 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.

11.28 Health Insurance.
Insurance providing a health care benefit or payment of an incurred health care expense.

11.29 Health Plan.
Coventry Health and Life Insurance Company

11.30 Home Health Care.
Health care services a person receives at home.

• Please see the Schedule of Benefits, Covered Services, and Exclusions for the specifics of Your Coverage.

11.31 Hospice Services.
A program of care for the terminally ill and their families, which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

11.32 Hospital.
An institution, operated pursuant to law, which: (a) is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a
place for rest, custodial care or care of the aged, a nursing home, convalescent home or similar institution is not a Hospital.

11.33 **Hospital Outpatient Care.**
Care in a Hospital that usually doesn’t require an overnight stay.

11.34 **Hospitalization.**
Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

11.35 **Inherited Metabolic Disease.**
A disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism or malabsorption of amino acid, organic acid, carbohydrate or fat.

11.36 **In-Network Coinsurance.**
The percent (for example, 20%) You pay of the Allowed Amount for Covered Services to Providers who Contract with Us.

11.37 **In-Network Copayment.**
A fixed amount (for example, $15) You pay for covered health care services to Providers who Contract with Us.

11.38 **In-Network Provider, Participating Provider, or Preferred Provider.**
A Provider who has entered into a direct or indirect contract with Us to provide services to You at a discount.

11.39 **Infertility.**
Any medical condition causing the inability or diminished ability to reproduce.

11.40 **Mail Order.**
A 90-day supply of an approved Maintenance Drug obtained through a participating Mail Order Pharmacy.

11.41 **Mail Order Pharmacy.**
Where applicable, a Participating Pharmacy contracted by Us to provide Maintenance Drugs through the mail.

11.42 **Maintenance Drug(s).**
Those Prescription Drugs which are prescribed for long-term or chronic conditions, such as high blood pressure or diabetes, not written for episodic treatments of medical conditions, and designated by Us as Maintenance Drugs. The list of Maintenance Drugs is available for review on Our website, or by contacting our Customer Service Department.

11.43 **Maximum Allowable Cost (MAC).**
The price assigned to Prescription Drugs that will be covered at the generic product level, subject to periodic review and modification by Us.

11.44 **Medical Benefit**
Those Covered Services set forth in the Schedule of Covered Services that are not described or included in the Prescription Drugs Section of the Schedule.

11.45 **Medical Necessity / Medically Necessary.**
Health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
a. in accordance with generally accepted standards of medical practice in the United States;
b. clinically appropriate in terms of type, frequency, extent, site, and duration;
c. not primarily for the convenience of the Member, Physician, or other health care Provider; and
d. covered under this Contract; and

1. When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

a. For interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence.
b. For established interventions, the effectiveness shall be based on:
i. Scientific Evidence;
ii. professional standards; and
iii. expert opinion.

11.46 Member.  
Any Subscriber or Dependent who enrolled for Coverage under this Contract in accordance with its terms and conditions.

11.47 Member Effective Date.  
The date entered on Our records as the date when Coverage for a Member under this Contract begins in accordance with the terms of this Contract, which Coverage shall begin at 12:01 a.m. on such date.

11.48 Network.  
The facilities, Providers and suppliers We have contracted with to provide health care services.

11.49 Non-Formulary Drugs.  
Prescription Drugs that are not included on Our Formulary at the time the Prescription Drug is dispensed to a Member.  Non-Formulary Drugs may include either generic or brand-name Prescription Drugs.

11.50 Non-Participating Pharmacy.  
Any registered, licensed pharmacy with whom Our pharmacy benefit administrator or We do not have a contract.

11.51 Non-Preferred Pharmacy.  
A Pharmacy that is a Participating Pharmacy, but is not a Preferred Pharmacy.

11.52 Non-Preferred Provider, Non-Participating Provider, or Out-of-Network Provider.  
A Provider who doesn’t have a Contract with Us to provide services to You.

11.53 Out-of-Network Rate (ONR).  
The Allowed Amount for Covered Services rendered by Non-Participating Providers for Out-of-Network Covered Services.  See Section 1.8 for more information on the Out-of-Network Rate.

11.54 Out-of-Pocket Maximum.  
The limit on the total amount of Coinsurance, Copayments and Deductibles You must pay out of Your pocket annually for In-Network Covered Services.
11.55 Participating Pharmacy.
   Any registered, licensed retail pharmacy with whom the pharmacy benefit administrator or We have a contract to dispense Prescription Drugs to Members.

11.56 Participating Provider.
   A Provider who has entered into a direct or indirect written agreement with Us to provide health services to Members.

11.57 Patient Costs.
   Any fee or expense for a Medically Necessary service incurred as a result of treatment provided to the Member for purposes of a clinical trial for the treatment of cancer. Patient Costs do not include the cost: (a) of any drug or device provided in a phase I or II cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a Member to receive treatment or intervention; (d) of managing the research of the clinical trial; and (e) that would not be covered under the Plan.

11.58 Physician.
   A duly licensed doctor of medicine or osteopathy practicing within the scope of the license.

11.59 Physician Services.
   Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

11.60 Plan.
   A benefit plan that provides for Your health care services.

11.61 PPACA.
   Patient Protection and Affordable Care Act of 2010, including any regulations promulgated thereunder.

11.62 Preferred Pharmacy.
   Those Participating Pharmacies that are identified as Preferred Pharmacies by Us. Please contact Our Customer Service Department for a list of Preferred Pharmacies.

11.63 Premium.
   The amount that must be paid for Your Health Insurance or Plan. You usually pay it monthly, quarterly, or yearly.

11.64 Prescribing Provider.
   Any person holding the degree of doctor of medicine, doctor of osteopathy, doctor of dental medicine or doctor of dental surgery or any other health care professional who is duly licensed in the state in which the Prescription Drug is prescribed to prescribe medications in the ordinary course of his or her professional practice.

11.65 Prescription Drugs.
   A drug that:

   • is provided for outpatient administration; and
   • has been approved by the Food and Drug Administration for a specific use; and
   • under federal or state law, can be dispensed only pursuant to a Prescription Order (legend drug); and
   • has not been otherwise limited or excluded under this Contract.
This definition includes some limited over-the-counter medications or disposable medical supplies (e.g., insulin and diabetic supplies). It includes medications for treatment of certain types of cancer approved by the Federal Food and Drug Administration and proven effective and accepted for the treatment of a specific type of cancer in any one of the following established reference compendia:

- The American Medical Association Drug Evaluations;
- The American Hospital Formulary Service Drug Information; or
- The United States Pharmacopeia Drug Information.

A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug.

11.66 Prescription Order or Refill.
The authorization for a Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

11.67 Primary Care Provider.
A Participating Provider who has been approved by Us to provide, supervise, and coordinate initial and basic care to Members, to maintain the continuity of patient care, and to initiate a referral to a Specialist, when appropriate under this Contract. The following specialty designations may be listed as "PCPs" in the Directory of Health Care Providers: General Practice, Family Practice, Internal Medicine, and Pediatrician.

11.68 Prior Authorization.
A decision by Us that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary and covered under your Plan. We may require Prior Authorization for certain services before You receive them, except in an emergency. Prior Authorization does not guarantee payment. We will not pay if You are not eligible for Covered Services at the time the service is provided.

11.69 Provider.
Any person, organization, health facility or institution licensed and operating within the scope of such license to deliver or furnish health care services.

11.70 Qualified Individual.
A Qualified Individual is an individual that has been determined to be eligible to enroll in Our Plan, pursuant to the requirements of 45 C.F.R. §156.155, which includes individuals who either: (i) Have not attained the age of 30 prior to the first day of the Contract year or (ii) have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of PPACA.

11.71 Rehabilitation Services.
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

11.72 Schedule of Benefits, Covered Services, and Exclusions.
Your Schedule of Benefits, Covered Services, and Exclusions lists the services available to You under the Contract, as well as the Deductibles, Coinsurance, and Copayments associated with each service. There are other factors that impact how Your Coverage works and those are included here in the Exclusions & Limitations.
11.73 Scientific Evidence.

1. Scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

2. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

Scientific Evidence does not include published, peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer, or a single study without other supportable studies.

11.74 Self-Administered Injectables.

Prescription Drugs that as defined by Us are commonly and customarily administered by the Member and are Covered only when dispensed by the Specialty Pharmacy or other Pharmacy designated by Us. Examples of Self-Administered Injectables include, but are not limited to, the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents and heparin products. Note: For definition purposes, other injectable drugs that are acquired through the retail Pharmacy, injectable diabetes agents (such as insulin and glucagons), bee sting kits, Immitrex and injectable contraceptives are not considered to be Self-Administered Injectables.

11.75 Service Area.

The geographical area defined by Us and approved by the appropriate regulatory agency. The Service Area for this Agreement is the State of Nevada.

11.76 Special Food Product.

A food product specially formulated to have less than one gram of protein per serving intended to be consumed under the direction of a Physician. The term does not include food that is naturally low in protein.

11.77 Specialist.

A Physician Specialist focuses on a specific area of medicine or to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has more training in a specific area of health care.

11.78 Specialty Drugs.

Defined by Us. Typically high-cost drugs, including but not limited to oral, topical, inhaled, inserted or implanted and injected routes of administration. These are identified in the Formulary with “SP” next to the name of the drug. Included characteristics of Specialty Drugs are that they:

(i) are used to treat and diagnose rare or complex diseases;
(ii) require close clinical monitoring and management;
(iii) frequently require special handling; and
(iv) may have limited access or distribution.

11.79 Specialty Pharmacy.

A pharmacy that has a contract with Us and is designated by Us as a Specialty Pharmacy who provides certain Covered Drugs, including, but not limited to, Prescription Drugs and Self-Administered Injectable and Specialty Drugs Orders or Refills.

11.80 Subscriber.

The individual in whose name this Contract is issued.
11.81 **Urgent Care.**
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

If a condition requiring Urgent Care develops, You must use Participating Providers or Participating Urgent Care Centers, unless the urgent condition occurs while you are outside the State of Nevada. Treatment may be subject to a Copayment and/or Coinsurance. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain.

11.82 **Value Formulary or Tier Zero Drugs.**
Group of medications on the Formulary addendum, Value Formulary Tier Zero Drugs, that are available for a limited period of time at no Copayment to Members who meet the plan criteria specified in the Formulary addendum.

11.83 **We, Us, Our.**
Coventry Health and Life Insurance Company.

11.84 **You / Your.**
A Member Covered under this Contract.