HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Small Business
Evidence Of Coverage

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

This Small Business Group Evidence of Coverage ("EOC") describes the healthcare plan made available to Eligible Employees of the Employer (referred to as "Group") and their Eligible Family Members.

Health Plan of Nevada, Inc. ("HPN"), and the Group have agreed to all of the terms of this EOC, and the EOC has been incorporated by reference into the Group Enrollment Agreement ("GEA") entered into by HPN and Group. This Plan is guaranteed renewable. This EOC may be terminated by HPN or the Group upon appropriate written notice in accordance with the GEA. The Group is responsible for giving Members notice of termination.

This EOC and your attached Attachment A Benefit Schedule tell you about your benefits, rights and duties as an HPN Member. They also tell you about HPN's duties to you.

This EOC including Attachment A Benefit Schedule and any other Attachments, Endorsements, Riders or Amendments to it, your Enrollment Form, health statements, Member Identification Card and all other applications received by HPN are all part of your HPN membership package. Please read them carefully and keep them in a safe place. **Words that are capitalized are defined in Section 14. - Glossary.**

Please carefully review your EOC and your Attachment A Benefit Schedule to determine which Covered Services require Prior Authorization. Failure of the Member to comply with the requirements of HPN's Managed Care Program and the Prior Authorization process will result in a denial or reduction of benefits.

Table of Contents

The Department of Business and Industry

State of Nevada

Division of Insurance

Telephone Numbers for Consumers of Healthcare

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

Hours of operation for the Division:

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

Contact information for the Division:

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

Las Vegas Office:
Phone: (702) 486-4009
Fax: (702) 486-4007
3300 W. Sahara Ave., Suite 275
Las Vegas, NV 89102

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

1-800-992-0900

Please listen to the greeting and select the appropriate prompt.

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

Address:

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

Phone:

1-800-777-1840

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

SECTION 1. Eligibility, Enrollment and Effective Date

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

1.1 Who Is Eligible

Subscriber. To be eligible to enroll as a Subscriber, an employee must be an employee of the enrolling Group or other person whose connection with the enrolling Group meets the eligibility requirements specified in both the application and the policy and meets the following criteria:

- Be employed full-time;
- Be in an active employment status;
- Work at least the minimum number of hours per week indicated by the Group in its Attachment A to the Group Enrollment Agreement (GEA);
- Meet the applicable waiting period indicated by the Group in its Attachment A to the GEA;
- Enroll during an enrollment period;
- Work for an employer that meets the minimum employer contribution percentage for the applicable coverage as set forth in the Attachment A to the GEA; and
- Live or work in the HPN Service Area.

The active employment status requirement will not apply to individuals covered under Group's prior welfare benefit plan on the date of that plan's discontinuance, provided that this EOC is initially effective no more than sixty (60) days after the prior plan's discontinuance. All other requirements will apply to such individuals.

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

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- A registered domestic partner.
- A child by birth. Adopted child. Stepchild. Minor child for whom a court has ordered coverage. Child being Placed for Adoption with the Subscriber. A child for whom a court has appointed the Subscriber or the Subscriber's spouse the legal guardian.

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

- A Dependent includes any child listed above under the limiting age of 26.
- A Dependent includes a Dependent child who is incapable of self-sustaining employment due to mental or physical handicap, chiefly dependent upon the Subscriber for economic support and maintenance, and who has satisfied all of the requirements of (a) or (b) below:
    a. The child must be covered as a Dependent under this Plan before reaching the limiting age, and proof of incapacity and dependency must be given to HPN by the Subscriber within thirty-one (31) days of the child reaching the limiting age; or
    b. The handicap started before the child reached the limiting age, but the Subscriber was covered by another health insurance carrier that covered the child as a handicapped Dependent prior to the Subscriber applying for coverage with HPN.

HPN may require proof of continuing incapacity and dependency when the child reaches the limiting age. HPN's determination of eligibility is final.

Evidence of any court order needed to prove eligibility must be given to HPN.

1.2 Who Is Not Eligible

Eligible Dependent does not include:

- A foster child.
- A child placed in the Subscriber's home other than for adoption.
- A grandchild.
- Any other person not defined in Section 1.1.

1.3 Changes In Eligibility Status

It is the Subscriber's responsibility to give HPN written notice within thirty-one (31) days of changes which affect his Dependent's eligibility. Changes include, but are not limited to:

- Reaching the limiting age.
- Ceasing to satisfy the mental or physical handicap requirements.

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

If the Subscriber fails to give notice which would have resulted in termination of coverage, HPN shall have the right to terminate coverage in accordance with the Group Enrollment Agreement.

1.4 Enrollment

Eligible Employees and Eligible Family Members must enroll during one of the Enrollment Periods described below or within thirty-one (31) days of first becoming eligible in order to have coverage under this Plan.

1. **Initial Enrollment Period.** An Initial Enrollment Period is the period of time during which an Eligible Employee and Eligible Family Member may enroll under this Plan as shown in the GEA signed by the Group.

2. **Group Open Enrollment Period.** An Open Enrollment Period of at least thirty-one (31) days may be held at least once a year allowing Eligible Employees and Eligible Family Members to enroll under this Plan.

3. **Special Enrollment Period**. A Special Enrollment Period allows a Special Enrollee to enroll for coverage under this Plan upon a Special Enrollment Event as defined herein during a period of at least thirty-one (31) days following the Special Enrollment Event.

4. **Right to Deny Application.** HPN can deny membership to any person who:
   a. Violates or has violated any provision of the HPN EOC.
   b. Misrepresents and/or fails to disclose a material fact which would affect coverage under this Plan.
   c. Fails to follow HPN rules.
   d. Fails to make a premium payment.

5. **Right to Deny Application for Renewal.** As a condition of Group's renewal under this Plan, HPN may require Group to exclude a Subscriber and/or Dependent who committed fraud upon HPN or misrepresented and/or failed to disclose a material fact which affected his coverage under this Plan.

1.5 Effective Date of Coverage

Before coverage can become effective, HPN must receive and accept premium payments and an Enrollment Form for the person applying to become a Member.

When a person applies to become a Member on or before the date he is eligible, coverage starts as shown in the GEA signed by the Group.

- If a person applies to be a Member within thirty-one (31) days of the date he is first eligible to apply, coverage the first day of the month following the last day of the required waiting period(s) as stated in the Group's GEA.

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

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

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

- If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber enrolls

the Dependent and pays any Dependent's premium. A copy of the court order must be given to HPN.

- For a Special Enrollee, the Effective Date of Coverage is on the first day of the calendar month after an Enrollment Form is received, unless otherwise specified in the GEA.

- When a person applies to become a Member during the Open Enrollment Period, coverage starts on the first day of the calendar month following the Open Enrollment Period.

The Subscriber must give HPN a copy of the certified birth certificate, decree of adoption, or certificate of Placement for Adoption for coverage to continue after thirty-one (31) days for newborn and adopted children. The Subscriber must give HPN a copy of the certified marriage certificate or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. Termination

This section tells you under what conditions your coverage under this Plan will terminate and the date that the coverage will end. In the event a Member's coverage terminates pursuant to Sections 2.1 and 2.2 below, the coverage of his Dependents will also terminate.

2.1 Termination by HPN

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

- Failure to maintain eligibility requirements as set forth in Section 1.
- On the first day of the month that a payment was due and was not received by HPN.
- With thirty (30) days written notice, if the Member allows his, or any other Member's, HPN ID Card to be used by any other person, or uses another person's HPN ID Card. The Member will be liable to HPN for all costs incurred as a result of the misuse of the HPN ID Card.
- If the Member performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, HPN has the right to rescind coverage and declare coverage under the Plan null and void follows:
    - for a material breach that occurred in the application process, rescission of coverage back to the original Effective Date of Coverage, with a refund any applicable premium; or
    - for any other act of fraud, termination effective no earlier than the date that the fraud had taken place.

  Thirty (30) days written notice shall be provided to the Member prior to any rescission of coverage. A Member has the right to appeal any such rescission.

- Subject to Section 3, Continuation of Coverage, on the last day of the calendar month (or sooner, if provided in the GEA) when a Member no longer meets the requirements of Section 1.; this paragraph also applies to Dependents who become ineligible as Members for any reason including the death of the Subscriber.
- On the 61st day after a change in residence if a Member moves his primary residence outside HPN's Service Area. A Subscriber may continue coverage after a change in residence as long as his place of work is within HPN's Service Area. During the sixty (60) consecutive day period after the change in residence, the only Covered Services that HPN will provide outside HPN's Service Area are Emergency Services and Urgently Needed Services.
- When a Subscriber or Dependent moves his primary residence outside HPN's Service Area and/or the Subscriber no longer has his place of work within HPN's Service Area, Subscriber must notify HPN within thirty-one (31) days of the change.
- On the date the GEA terminates for any reason, including but not limited to:
    - Nonpayment of premiums.
    - Failure to meet minimum enrollment requirements.
    - HPN amends this EOC and the Group does not accept the amendment.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under this Plan by written notice to HPN. Such termination is effective on the last day of the month in which the notice is received by HPN, unless stated otherwise in the GEA.

2.3 Reinstatement

Any EOC which has been terminated in any manner may be reinstated by HPN at its sole discretion.

2.4 Retroactive Termination

A request for retroactive termination by Group may be granted as shown in the GEA.

2.5 Effect of Termination

No benefits will be paid under this Plan by HPN for services provided after termination of a Member's coverage under this Plan. The Member will be responsible for payment of medical services and supplies incurred after the Effective Date of the termination of this Plan and/or the GEA.

SECTION 3. Continuation of Coverage

This section tells you under what conditions your coverage can continue at Group rates in certain instances for a limited period of time when coverage under the Group Health Benefit Plan ends.

3.1 COBRA

The following rules apply only to Groups with twenty (20) or more employees on 50% of the workdays in the previous Calendar Year. For the purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1989 (OBRA), Group shall be considered the Plan Administrator.

Important Note: This EOC does not, and cannot, contain all of the information that is required under the COBRA continuation coverage regulations. Federal laws and regulations regarding COBRA are publicly available.

a) A Subscriber and any enrolled Dependent who would lose coverage under this Plan because of: 1) a reduction in the Subscriber's regularly scheduled work hours, or 2) because of termination of the Subscriber's employment with the Group for any reason, other than gross misconduct, has the right to elect COBRA continuation coverage. Such coverage may continue for up to eighteen (18) months.

   The premium for this COBRA continuation coverage may be increased to 102% of the premium for providing coverage to other Subscribers under this Plan. COBRA continuation coverage will not take effect until the Subscriber or Dependent elects COBRA and makes the required payment. The Subscriber or Dependent will have an initial grace period of forty-five (45) days from the date of COBRA election to make the first premium payment.

   If the qualifying event is: 1) a reduction in the Subscriber's regularly scheduled work hours, or 2) because of termination of the Subscriber's employment with the Group for any reason other than gross misconduct and the Subscriber became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, then COBRA continuation coverage for Dependents may continue for up to thirty-six (36) months after the initially determined date of Medicare entitlement.

b) A Dependent who would lose coverage under this Plan due to any of the qualifying events shown below has the right to elect COBRA continuation coverage. Such coverage may continue for up to thirty-six (36) months.
   i) The Subscriber's death.
   ii) The Subscriber's divorce or legal separation.
   iii) The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.
   iv) A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

   The premium for continuation coverage may be increased to 102% of the premium for providing coverage to other individuals under this Plan.

c) **Election of COBRA Continuation Coverage**. A Subscriber or Dependent identified in 3.1(a) or (b) above must elect to continue coverage within sixty (60) days of the election notice which qualifies him to continue coverage. If the election is not made within sixty (60) days, the Subscriber or Dependent is not eligible to continue coverage under this Plan.

   Each Subscriber or Dependent will have an independent right to elect COBRA continuation coverage. Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

   Plans Offered Under COBRA Continuation Coverage. Subscribers and Dependents who qualify and elect COBRA continuation coverage must be offered the same Plan as similarly situated employees for whom a qualifying event has not occurred. When a qualified Subscriber or his Dependent leaves HPN's Service Area, they will be given the opportunity to elect alternate coverage that the Group makes available to its active employees.

   For purposes of COBRA continuation coverage, "similarly situated employees" means the group of covered employees, spouses of covered employees, or Dependent children of covered employees receiving coverage under a Group Health Benefit Plan maintained by the employer. Similarly situated employees receive healthcare coverage for a reason other than under COBRA

continuation coverage and who, based on all of the facts and circumstances are most similarly situated to the circumstances of the qualified Subscriber immediately before the qualifying event.

For the purposes of determining the cost of COBRA continuation coverage, the Plan is entitled to take into account the Plan under which COBRA continuation coverage is provided.

d) **Notice from Plan Administrator (Group)**. The Plan Administrator will have up to forty-four (44) days from the qualifying event to provide the Subscriber or Dependent with the COBRA election notice which contains information concerning the actions required to elect COBRA continuation coverage and the premium to be paid. The Plan Administrator has the sole obligation to provide the Subscriber or Dependent with a notice of unavailability in the event that the Plan Administrator determines that such Subscriber or Dependent is not entitled to COBRA continuation coverage. HPN assumes no responsibility for the Plan Administrator's failure to provide COBRA notifications to the eligible Members.

HPN assumes no further obligation to provide COBRA continuation coverage if:

- The Plan Administrator does not notify the Member within forty-four (44) days of the qualifying event; or
- The Member does not make a timely election; or
- The Plan Administrator fails to notify HPN of the election within thirty (30) days of the election; or
- Timely premium payments are not made as described in 3.1(f).

There are two (2) ways in which the eighteen (18)-month period of COBRA continuation coverage identified in 3.1(a) can be extended:

1. **Disability Extension**. If a Subscriber or Dependent covered under the Plan is disabled as determined under Title II (OASDI) or Title XVI (SSI) of the Social Security Act (SSA), COBRA continuation coverage will be extended from eighteen (18) months up to a total maximum of twenty-nine (29) months, provided the disability started at some time before the sixtieth (60th) day of COBRA continuation coverage, continues until the end of the eighteen (18)-month period of COBRA continuation coverage, and notice is received by Group before the initial eighteen (18)-month period expires.

   The premium for the extension period of COBRA continuation coverage will be increased to 150% of the applicable Group premium for providing coverage to other Subscribers under this Plan. During the extended period, a disabled individual's coverage will be terminated automatically as of the first day of the month that is more than thirty (30) days after a final determination that the Subscriber or Dependent is no longer disabled.

   The individual is required to notify the Group within thirty (30) days of such determination. Disabled individuals are also subject to termination as set forth in 3.1(f).

2. **Second Qualifying Event Extension**. If a second qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, an enrolled spouse and Dependent children can qualify for eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan.
   This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Subscriber or former Subscriber:
   - dies;
   - becomes entitled to Medicare benefits (under Part A, Part B, or both);
   - gets divorced or legally separated; or
   - if the Dependent child no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

e) **Required Notification**. The Subscriber or Dependent must notify Group and Group must notify HPN within sixty (60) days beginning from the latest of:

1. the date on which the relevant qualifying event occurs;
2. the date on which there is a loss of coverage under the Plan as a result of the qualifying event; or
3. the date on which the Subscriber or Dependent is informed through the Plan's EOC or the general COBRA notice of their obligation to provide notice and the procedures for providing such notice.

The Subscriber or Dependent must provide notice to Group of any of the following qualifying events:

- A Subscriber's divorce.
- A Subscriber's legal separation.
- A Dependent no longer meets HPN's eligibility rules.
- A second qualifying event after a Subscriber or Dependent has become entitled to COBRA continuation coverage with a maximum duration of eighteen (18) or twenty-nine (29) months.

- A Subscriber or Dependent entitled to receive COBRA continuation coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration under Title II or XVI of SSA to be disabled at any time during the first sixty (60) days of COBRA continuation coverage.

  The Member who seeks the disability extension must notify the Plan Administrator and HPN of the Social Security Administration disability determination no later than sixty (60) days after the latest of:

  1. The date of Social Security Administration determination;
  2. The date on which the qualifying event occurs;
  3. The date on which the Subscriber or Dependent loses coverage under the Plan as a result of a qualifying event;
  4. The date on which the Subscriber or Dependent is informed through the Plan's EOC or the general COBRA notice of their obligation to provide notice.

- A disabled Subscriber or Dependent, who has subsequently been determined by the Social Security Administration under Title II or XVI of the SSA to no longer be disabled.
- If a Member is determined by the Social Security Administration to no longer be disabled, the Member must notify the Plan of that fact within thirty (30) days after the Social Security Administration's determination.

Any Subscriber, Dependent or any representative designated or authorized to act on behalf of the Subscriber or Dependent may provide the notice and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of the Subscriber and all Dependents with respect to the qualifying event.

f) **Non-Eligibility and Termination**. In addition to HPN's other rights to terminate this coverage as shown in Section 2., COBRA continuation coverage will not be allowed or shall be terminated prior to the end of the applicable eighteen (18)-month period, the nineteen (19) to twenty-nine (29) month extension period for the disability extension, or thirty-six (36)-month period for Dependents, if any of the following occur:

- The GEA is terminated in its entirety.

- The Subscriber, spouse or Dependent fails to pay premiums in full when due.

  The Subscriber or Dependent will have a one-time only initial grace period of forty-five (45) days from the date of COBRA election to make the first premium payment. Thereafter, payments for COBRA continuation coverage are due by the first day of each monthly period to which the payment applies (payments must be postmarked on or before the thirty (30)-day grace period).

  If you do not make payments on a timely basis, COBRA continuation coverage will terminate as of the last day of the period for which timely payment was made.

- The Subscriber or Dependent becomes eligible for coverage under another Group Health Benefit Plan.

- The divorced spouse remarries and becomes eligible for coverage under another Group Health Benefit Plan.

- The Subscriber or Dependent becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA continuation coverage.

- A disabled Subscriber is found to be no longer disabled.

The Plan Administrator has the sole obligation to provide the Subscriber or Dependent with a notice of termination in the event that COBRA continuation coverage is terminated prior to the end of the maximum period. HPN assumes no responsibility for the Plan Administrator's failure to provide such notification to the eligible Members.

g) **Address Changes**. The Member shall be responsible for notifying Group of any changes in the addresses of enrolled Dependents.

h) **Plan Contact Information**. For additional information about the Plan or your rights under COBRA continuation coverage, contact HPN's Member Services Department by calling 1-800-777-1840.

i) **COBRA and FMLA**. If the Subscriber has taken a leave of absence under the Family Medical Leave Act of 1993 (FMLA) and does not return to work at the end of the FMLA leave, the Subscriber and Dependents may elect COBRA continuation coverage for up to eighteen (18) months from the earliest to occur of the following:

- The date that the Subscriber states that they will not be returning to work at the end of the leave;
- The end of the approved leave, assuming that the Subscriber does not return; or
- The date that the FMLA entitlement ends.

For purposes of an FMLA leave, the Subscriber and Dependents will be eligible for COBRA continuation coverage only if:

- The Subscriber and Dependents are covered by the Group Health Benefit Plan on the day before the leave begins (or become covered during the FMLA leave);
- The Subscriber does not return to employment at the end of the FMLA leave; and
- The Subscriber or Dependents lose coverage under HPN's Group Health Benefit Plan before the end of what would be the maximum COBRA continuation coverage period.

3.2 Federal Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

For Groups of any size, the Subscriber or any Dependents shall have the right to continue Group coverage as follows.

(a) **Eligibility**. In the event that Subscriber and any Dependent would lose coverage under the Plan because of Subscriber's absence from work due to Subscriber's service in the uniformed services, Subscriber may elect to continue coverage under the Plan on behalf of Subscriber and any Dependents.

(b) **Duration of COBRA Continuation Coverage**. The maximum period of COBRA continuation coverage under this section shall be the lesser of:

1. the 24-month period beginning on the date on which the Subscriber's absence from work begins; or

2. the day after the date on which the Subscriber fails to apply for or return to work with the Group as follows:

   a) If the Subscriber served in the uniformed services and is absent from work for less than thirty-one (31) days;
      1) COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of service and the expiration of eight (8) hours after a period allowing for the Subscriber's transportation from the place of that service to the Subscriber's residence; or
      2) as soon as possible after the expiration of the eight (8) hour period referred to in (1) if reporting within the period under (1) is impossible or unreasonable through no fault of the Subscriber.

   b) If the Subscriber is absent from work for any period for purposes of determining the Subscriber's fitness to perform service in the uniformed service, not later than the period described in (1) above.

   c) If the Subscriber served in the uniformed services and is absent from work for more than thirty (30) days but less than 181 days, COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment, which must not be later than fourteen (14) days after completion of the period of service. If applying within that period is impossible or unreasonable through no fault of the Subscriber, then the application for reemployment must be made by the next first full calendar day when applying becomes possible.

   d) If the Subscriber served in the uniformed services and is absent from work for more than 180 days, COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than ninety (90) days after completion of such period of service.

(c) **Premium for COBRA Continuation Coverage.** A Subscriber electing COBRA continuation coverage under this section shall be responsible for paying the applicable premium for such coverage. The premium for COBRA continuation coverage shall not exceed 102% of the applicable premium for providing coverage to other Subscribers of the Group. However, if the Subscriber performs service in the uniformed services for less than thirty-one (31) days, the Subscriber shall be liable only for the premium contribution (if any) that the Subscriber was paying for coverage under the Plan immediately prior to serving in the uniformed services.

3.3 Total Disability of Subscriber

For Groups of any size, continuation of coverage shall be offered to each Subscriber and their Dependents who are otherwise covered by this Plan while the Subscriber is on leave without pay (as defined by the GEA), as a result of Total Disability. This coverage is for any Injury or Illness suffered by the Subscriber, which is not related to the Total Disability or for any Injury or Illness suffered by a Dependent. This coverage will continue, subject to the payment of the applicable premium, until the earliest to occur of:

- The date Subscriber's employment is terminated.
- The date Subscriber obtains other healthcare coverage on an insured or self-insured basis.
- The date the GEA is terminated.
- After a period of twelve (12) months during which benefits for such coverage are provided to the Subscriber.
- The date the Subscriber no longer resides or works within the HPN Service Area or a Dependent no longer resides within the HPN Service Area.

NOTE: In this Section 3., "Totally Disabled" or "Total Disability" refers to the continuing inability of the Subscriber to substantially perform duties related to his employment. Coverage is equal to coverage provided in this Plan.

3.4 Non-Election

For Groups of any size, if a Subscriber and/or Dependent does not elect to continue coverage under the Group Plan, or does not qualify for continuation of coverage, coverage under this Plan shall terminate on the date provided for in this EOC.

3.5 State Law

In the event that applicable state law requires different continuation of coverage provisions for any size Group, the provisions required by such state law will apply.

SECTION 4. Managed Care Program

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

4.1 Managed Care Program

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

4.2 Managed Care Program Requirements

HPN's Managed Care Program requires the Member, Plan Providers and HPN to work together. All Plan Providers have agreed to participate in HPN's Managed Care Program. Plan Providers have agreed to accept HPN's Reimbursement Schedule amount as payment in full for Covered Services, less the Member's payment of any applicable Calendar Year Deductible, Copayment or Coinsurance amount, whereas Non-Plan Providers have not.

Members enrolled under HPN's HMO Plans who use the services of Non-Plan Providers will receive no benefit payments or reimbursement for amounts for any Covered Service, except

- in the case of Emergency Services or Urgently Needed Services; or
- for other Covered Services, as defined in this EOC, provided by a Non-Plan Provider that **are** Prior Authorized by HPN's Managed Care Program.

This includes any Prior Authorized Covered Services obtained from a Non-Plan outpatient facility, such as a laboratory, radiological facility (x-ray), or any complex diagnostic or therapeutic services. In no event will HPN pay more than the maximum payment allowance established in the HPN Reimbursement Schedule.

It is the Member's responsibility to verify that the Provider selected is a Plan Provider before receiving any non-Emergency Services and to comply with all other rules of HPN's Managed Care Program.

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

4.3 Managed Care Process

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

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

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

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

4.4 Services Requiring Prior Authorization

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

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility, Residential Treatment Center or Hospice.
- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.
- All Inpatient and non-routine Outpatient non-Emergency Mental Health, Severe Mental Illness, and Substance Related and Addictive Disorder Services, including:
    - Intensive outpatient program treatment.
    - Outpatient electro-convulsive treatment.
    - Psychological testing.
- All Specialist visits or consultations.
- Prosthetic Devices, Orthotic Devices and Durable Medical Equipment.
- Allergy testing or treatment (e.g., skin, RAST); angioplasty; physiotherapy or Manual Manipulation; and habilitative and rehabilitation therapy (physical, speech, occupational).

4.5 Emergency Admission Notification

The Member must report all emergency admissions to the Member Services Department by calling 1-800-777-1840 within twenty-four (24) hours of admission, or as soon as reasonably possible, to authorize continued care.

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

4.6 Appeals Rights

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

SECTION 5. Obtaining Covered Services

This section tells you under what conditions services are available under this Plan and your obligations as a Member. You should also carefully review the Exclusions and Limitations Sections (Section 7. and Section 8. respectively) prior to obtaining any healthcare services.

5.1 Availability of Covered Services

Members are entitled to receive the Covered Services set forth in Section 6 herein and the Attachment A Benefit Schedule subject to all terms and conditions of this EOC, and payment of required premium. These Covered Services are available only if and to the extent that they are:

- Provided, prescribed or arranged by the Member's PCP;
- Specifically authorized through HPN's Managed Care Program;
- Received in HPN's Service Area through a Plan Provider; and
- Medically Necessary as defined in this EOC.

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

5.2 Agreement of Member

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

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

5.3 Continuity of Care from Plan Providers

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

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

- The 120th day following the date the contract was terminated between the Provider and HPN; or
- If the medical condition is pregnancy, the 45th day after the date of delivery or if the pregnancy does not end in delivery the date of the end of the pregnancy.

The Member or Plan Provider may submit a request for continuity of care to the address shown below. If the Plan agrees to the continued treatment, the Plan will pay for Covered Services at the Plan Provider level of benefits for a limited time, as outlined above. The Plan Provider may not seek payment from the Member for any amounts for which the Member would not be responsible if the Provider were still a Plan Provider.

Health Plan of Nevada, Inc.
PO Box 15645
Phone: 1-800-777-1840

Attn: Provider Services Department
Las Vegas, NV 89114-5645

SECTION 6. Covered Services

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

6.1 Healthcare Facility Services

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

Accommodations:

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

- Observation unit, including bed, board, and general nursing care not to exceed twenty-three (23) hours per day.
- Nursery charges for newborns. Reimbursement for Covered Services provided by a Non-Plan Provider outside HPN's Service Area to a newborn natural child or adopted child is limited to HPN's Eligible Medical Expense for similar Covered Services provided in HPN's Service Area.

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

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

6.2 Medical – Physician Services

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

- direct physical examination of the patient;
- examination of some aspect of the patient by means of pathology laboratory or electronic monitoring procedure which is a generally recognized and accepted procedure for diagnostic or therapeutic purposes in the treatment of an Illness or Injury;
- procedures for prescribing or administering medical treatment;
- Manual Manipulation (except for reductions of fractures or dislocations);
- treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints;
- anesthesia services;
- family planning services including sterilization procedures; and
- Limited diagnostic and therapeutic infertility services determined to be Medically Necessary by HPN and Prior Authorized by HPN's Managed Care Program. In order for the Member to be eligible for infertility benefits, all of the following criteria must be met. The Member:
    - Is a female under age 44**.**
    - Is not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
        - One year, if a female under age 35; or
        - Six months, if a female age 35 or older.
    - Has infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

  For the purposes of this benefit, "therapeutic donor insemination" means using a donor sperm sample to enable a female to become pregnant.

  Covered Services do not include those services specifically excluded in the Exclusions section herein, but do include limited:

  ✓ Laboratory studies.

  ✓ Diagnostic procedures.

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

6.3 Medical-Physican Consultations

Covered Services include medical services rendered by a Plan Specialist or other duly licensed Plan Provider whose opinion or advice (i.e., second or third opinion or consultation) is requested by a Member's PCP or the Medical Director) for further evaluation of an Illness or Injury on an Inpatient or outpatient basis. All services must be arranged through HPN's Managed Care Program.

Limitations. No payment will be made for expenses incurred for second or third opinions/consultations in connection with:

1. any services not covered under this Plan, including cosmetic and dental procedures;
2. minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions; or
3. diagnostic tests ordered in connection with second and third opinions/consultations, unless Prior Authorized by HPN's Managed Care Program.

6.4 Preventive Healthcare Services

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

Covered Services include the following Preventive Healthcare Services in accordance with the recommended schedule outlined in the HPN Preventive Guidelines included in your member kit or you may access the most current version of these guidelines at any time by visiting HPN's web site at https://www.healthplanofnevada.com.

- Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations[(1)] that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA, as long as they are not otherwise addressed by the recommendations of the USPSTF.

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

[(1)]Certain immunizations may be administered in a Plan pharmacy.

6.5 Physician Surgical Services – Inpatient and Outpatient

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

6.6 Oral Physician Surgical Services

Although dental services are not Covered Services, except as otherwise provide in the Attachment A Benefit Schedule, the following Oral Surgical Services are Covered Services:

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

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

6.7 Organ and Tissue Transplant Surgical Services

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

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

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

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

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

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

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

6.8 Assistant Surgical Services

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

6.9 Emergency or Urgently Needed Services

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

Benefits are limited to Eligible Medical Expenses for Non-Plan Provider Emergency Services as defined under "HPN Reimbursement Schedule". You are responsible for any Non-Plan Provider Emergency Service charges that exceed payments made by HPN.

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

IMPORTANT NOTE: No benefits are payable for treatment received by a Member in a Hospital emergency room or other emergency facility for a condition other than an Emergency Service as defined in this EOC.

Examples of conditions which require Medically Necessary treatment, but **are not Emergency Service**s, include:

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

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

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

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

   The Member should, at the earliest time reasonably possible, notify his PCP.

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

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

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

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

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

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

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

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

Free Standing Emergency Room Facilities

These facilities are licensed to provide emergency medical care and are physically separate from hospitals. However, unlike hospital-based emergency rooms, these facilities often do not provide services for critical conditions such as trauma, stroke, and heart attacks; most do not receive ambulances or have an operating room on site. Please contact the 24/7 Advice Nurse if you have questions on where to go to obtain the appropriate level of service.

6.10 Ambulance Services

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

6.11 Home Healthcare Services

Covered Services include services given to a Member in his home by a licensed Home Healthcare Provider or an approved Hospital program for Home Healthcare. Such services are covered when:

- such care is given in place of Inpatient Hospital or Skilled Nursing Facility care and/or;
- the Member is not physically able to obtain Medically Necessary care on an outpatient basis; and/or
- the Member is under the care of a Physician; and/or
- the Member is homebound for medical reasons.

NOTE: The Member is responsible for one cost-share per day per Home Healthcare agency.

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

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

6.12 Short-Term Rehabilitation Services – Inpatient and Outpatient

Short-Term Rehabilitation therapy Covered Services include:

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

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

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

6.13 Laboratory Services

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

6.14 Routine Radiological and Non-Radiological Diagnostic Imaging Services

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

6.15 Other Diagnostic and Therapeutic Services

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

- therapeutic radiology services;
- complex diagnostic imaging services including nuclear medicine, computerized axial tomography (CT scan), cardiac ultrasonography, magnetic resonance imaging (MRI) and arthrography;

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

Different Copayment and/or Coinsurance amounts may apply to these Covered Services. Please refer to your Attachment A Benefit Schedule.

6.16 Prosthetic and Orthotic Devices

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

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

6.17 Corrective Appliances

Corrective Appliances are devices that are designed to support a weakened body part and are manufactured or custom-fitted to an individual. Covered Services include custom-made or custom-fitted Medically Necessary Corrective Appliances when Prior Authorized by HPN's Managed Care Program, to include the following:

- Rigid Cervical Collars;
- Abdominal Binder/Corsets;
- Shoes when prescribed for a diabetic condition, otherwise only when an integral part of a lower body brace;
- Helmets when prescribed in connection with cranial orthosis.

Corrective Appliances do not include:

- Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics; or
- Deluxe upgrades determined not to be Medically Necessary.

Replacements, repairs and adjustments to Corrective Appliances are Covered Services when required by normal wear and tear or by a significant change in the Member's condition when ordered by a duly-licensed Provider.

6.18 Durable Medical Equipment

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

- Braces;
- Canes;
- Crutches;
- Intermittent positive pressure breathing machine;
- Hospital beds;
- Standard outpatient oxygen delivery systems;
- Traction equipment;
- Walkers;
- Wheelchairs; or

- Any other items that are determined to be Medically Necessary by HPN's Managed Care Program.

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

HPN will not be responsible for the following:

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

6.19 Mental Health Services and Severe Mental Illness Services

All benefits are subject to the Utilization Management process through Behavioral Healthcare Options (BHO). Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care.

Inpatient: A structured hospital-based program which provides twenty-four (24) hours a day, seven (7) days a week nursing care, medical monitoring, and physician availability; assessment and diagnostic services, daily physician visits, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the Member or others.

Partial Hospitalization Programs (PHP): A structured program that maintains hours of service for at least twenty (20) hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided.

Intensive Outpatient Programs (IOP): A structured program that maintains hours of service for at least nine (9) hours per week for adults and six (6) hours per week for children or adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided.

Outpatient: Assessment, diagnosis and active behavioral health treatment that are provided in an ambulatory setting, including individual and group counseling services.

Residential Treatment Center Services (RTC): A hospital-based program which provides twenty-four (24) hours a day, seven (7) days a week nursing care, medical monitoring, and physician availability; assessment and diagnostic services, daily physician visits and active behavioral health treatment services for the purpose of initiating the process of assisting a Member with gaining the knowledge and skills needed to prevent recurrence of a mental health-related disorder.

No benefits are available for psychosocial rehabilitation or care received as a custodial Inpatient.

All non-routine, outpatient Mental Health or Severe Mental Illness Services require Prior Authorization. Members must call BHO at (702) 364-1484 or 1-800-873-2246 for assistance in scheduling their first appointment in order to verify that any requested Mental Health or Severe Mental Illness Services are Covered Services under the Plan, and that such Covered Services will be obtained at the appropriate level of care in order to be eligible for full benefit payment. A BHO coordinator will either assist in scheduling the appointment or will make a referral to the appropriate Plan Provider based on the service requested and the associated level of acuity.

All inpatient Mental Health or Severe Mental Illness Services require Plan notification. Network facilities must provide notification of all inpatient admissions to the Plan. When these services are provided out of network, the Member is responsible for providing the notification and relevant information to the Plan. Members should provide notice of emergent admissions within twenty-four (24) hours of admission or as soon as reasonably possible given the circumstances. Members may delegate their responsibility to provide notification to the non-network facility but it is the Member's responsibility to ensure that the Plan receives notification. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.

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

6.20 Substance-Related and Addictive Disorder Services

All benefits for Substance-Related and Addictive Disorder Services are subject to the Utilization Management process through Behavioral Healthcare Options (BHO). Services must be offered in a treatment setting that is appropriate for the Medically Necessary level of care, as determined by staffing, ability to provide patient safety, treatment intensity, the diagnostic and therapeutic modalities available, the extent of supportive services and access to general medical care.

Inpatient Detoxification: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; daily physician visits, assessment, diagnostic services, and active behavioral health treatment services for the purpose of completing a medically safe and appropriate withdrawal from alcohol or other substances.

Outpatient Detoxification: Outpatient Detoxification is comprised of services that are provided in an ambulatory setting for the purpose of completing a medically safe withdrawal from alcohol or drugs.

Inpatient Rehabilitation: A hospital-based program which provides twenty-four (24) hours a day, seven (7) days nursing care, medical monitoring, and physician availability; daily physician visits, assessment and diagnostic services, and active behavioral health treatment services for the purpose of initiating the process of assisting a Member with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.

Partial Hospitalization Programs (PHP): A structured program that maintains hours of service for at least twenty (20) hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided.

Intensive Outpatient Programs (IOP): A structured program that maintains hours of service for at least nine (9) hours per week for adults and six (6) hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided.

Outpatient: Assessment, diagnosis and active behavioral health treatment that are provided in an ambulatory setting, including individual, group, and family counseling services.

Residential Treatment Center Services (RTC): A hospital-based program which provides twenty-four (24) hours a day, seven (7) days a week trained staff, medical monitoring, and physician availability; daily physician visits, assessment and diagnostic services, and active behavioral health treatment services for the purpose of initiating the process of assisting a Member with gaining the knowledge and skills needed to prevent recurrence of a Substance-Related and Addictive Disorder.

All non-routine, outpatient Substance-Related and Addictive Disorder Services require Prior Authorization. Members must call BHO at (702) 364-1484 or 1-800-873-2246 for assistance in scheduling their first appointment in order to verify that any requested Substance-Related and Addictive Disorder Services are Covered Services under the Plan, and that such Covered Services will be obtained at the appropriate level of care in order to be eligible for full benefit payment. A BHO coordinator will either assist in scheduling the appointment or will make a referral to the appropriate Plan Provider based on the service requested and the associated level of acuity.

All inpatient Substance-Related and Addictive Disorder Services require Plan notification. Network facilities must provide notification of all inpatient admissions to the Plan. When these services are provided out of network, the Member is responsible for providing the notification and relevant information to the Plan. Members should provide notice of emergent admissions within twenty-four (24) hours of admission or as soon as reasonably possible given the circumstances. Members may delegate their responsibility to provide notification to the non-network facility but it is the Member's responsibility to ensure that the Plan receives notification. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.

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

6.21 Mastectomy Reconstructive Surgical Services

Covered Services are provided in the same manner and at the same level as those for any other Covered Health Service, and also as required by the *Women's Health and Cancer Rights Act of 1998*, as follows:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient.

6.22 Special Food Product / Enteral Formulas

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

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

6.23 Self-Management and Treatment of Diabetes

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

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

6.24 Dental Anesthesia Services

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

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

Coverage for dental anesthesia pursuant to this section is limited to services provided by a Plan anesthesia Provider. Coverage is provided only during procedures performed by:

- an educationally qualified Specialist in pediatric dentistry; or
- another dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted; or
- who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

6.25 Gastric Restrictive Surgical Services

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

- Have a body mass index (BMI) of greater than or equal to 40kg/m2; or
- Have a BMI between 35.1-39.9kg/m2 with significant co-morbidities; and
- Can provide documented evidence that dietary attempts at weight control are ineffective; and
- Must be at least 18 years old.

Documentation supporting the reasonableness and necessity of a Gastric Restrictive Surgical Service is required, including compliant attendance at a medically supervised weight loss program (within the last twenty-four (24) months) for at least six (6) consecutive months with documented failure of weight loss. Significant clinical evidence that weight is affecting overall health and is a threat to life will also be required.

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

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

6.26 Genetic Disease Testing Services

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

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

6.27 Clinical Trial or Study

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

- The clinical trial or study is conducted in the state of Nevada and the medical treatment is provided:
    1. In a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or other life-threatening disease or condition;
    2. In a Phase II, Phase III or Phase IV clinical trial or study for the treatment of chronic fatigue syndrome;
    3. For cardiovascular disease (cardiac/stroke) which is not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
    4. For surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
    5. Other diseases or disorders which are not life-threatening, for which, as HPN determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- The clinical trial or study is approved by one of the following entities:
    1. An agency of the National Institutes of Health (NIH) as set forth in 42 U.S.C. § 281 (b);
    2. The Centers for Disease Control and Prevention (CDC);
    3. The Agency for Healthcare Research and Quality (AHRQ);
    4. Centers for Medicare and Medicaid Services (CMS);
    5. A cooperative group;
    6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
    7. The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet the both of following criteria:
        - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
        - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. HPN may, at any time, request documentation about the trial;
- The medical treatment is provided by a duly licensed Provider of healthcare and the facility and personnel have the experience and training to provide the medical treatment in a capable manner;
- There is no medical treatment available which is considered a more appropriate alternative than the medical treatment provided in the clinical trial or study;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; and
- The Member has signed a statement of consent before his participation in the clinical trial or study indicating that he has been informed of:
    1. The procedure to be undertaken;
    2. Alternative methods of treatment; and
    3. The risks associated with participation in the clinical trial or study.

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

- The initial consultation to determine whether the Member is eligible to participate in the clinical trial or study;

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

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

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

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

6.28 Medical Supplies

Medical Supplies are routine expendable supplies that are essential to carry out the course of treatment for an Illness or Injury or are necessary for the effective use of Durable Medical Equipment. Medical Supplies include, but are not limited to the following:

- Catheter and catheter supplies – urinary catheters, drainage bags, irrigation trays;
- Colostomy bags (and other ostomy supplies);
- Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lamb's wool pads,;
- Elastic stockings; and
- Splints and slings.

6.29 Post-Cataract Surgical Services

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

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

6.30 Hearing Aids

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) and purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Service for which benefits are available under the applicable medical/surgical Covered Services categories in the HPN EOC, only for a Member

- who is not a candidate for an air-conduction hearing aid; and
- which is used according to U.S. Food and Drug Administration (FDA) approved indications.

Benefits for bilateral bone anchored hearing aids are available to Members who meet the HPN Managed Care Program criteria.

6.31 Autism Spectrum Disorder Services

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders for Members under the age of 18 or, if enrolled in high school, until such Member reaches the age of 22. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst or other

provider that is supervised by the licensed physician, psychologist or behavior analyst and are subject to HPN's Managed Care Program. With the exception of the specific limitation on benefits for Applied Behavior Analysis ("ABA") as outlined in Attachment A Benefit Schedule, benefits for all Covered Services for the treatment of Autism Spectrum Disorders are payable to the same extent as other Covered Services and Covered Drugs under the Plan.

Covered Services for the treatment of Autism Spectrum Disorder Services do not include services provided through school services.

6.32 Pediatric Dental and Vision Services

Covered Services are available to enrolled children up to age (19) when authorized by HPN's Managed Care Program and ends the first of the month after the Member's 19th birthday.

Pediatric Vision coverage includes services for:
- Vision Examination;
- Lenses Frames;
- Contact Lenses;
- Low Vision Exam; and
- Optional Lenses and Treatments.

Pediatric Dental coverage includes:
- Diagnostic and Preventive Services;
- Restorative Services;
- Endodontic Services;
- Periodontic Services;
- Prosthodontic Services;
- Orthodontic Services; and
- Oral Surgery Services.

For a complete listing of Pediatric Dental Services and the associated limitations, please refer to the Nevada Division of Insurance website located at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits/.

Please refer to the HPN Attachment A Benefit Schedule for the associated Member cost share for Pediatric Dental and Vision Covered Services.

6.33 Short Term Habilitation Services

Covered Services are provided for Short Term Habilitation Services provided for Members with a congenital, genetic, or early acquired disorder when both of the following conditions are met:
- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist
- and the initial or continued treatment must be proven and not experimental, investigational or unproven.

HPN will cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

Short Term Habilitation Services that are provided in the home by a licensed Home Healthcare Provider are covered as described under the Home Healthcare Services section.

6.34 Telemedicine Services

Covered Services received through Telemedicine do not require Prior Authorization unless the Covered Service would require Prior Authorization if provided in person. The Member does not have to establish a relationship with a Telemedicine Provider to receive services. Telemedicine Services received through a contracted HPN Primary Care or Specialty Care Provider will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in Attachment A, Benefit Schedule.

HPN does not require the Provider to demonstrate the necessity to provide services through, or to receive additional certifications or licenses in, Telemedicine.

HPN will not refuse to provide coverage because of the distant site from which the contracted Telemedicine Provider provides Covered Services or the originating site at which the Member receives Telemedicine Services. HPN will not require Covered Services to be provided through Telemedicine as a condition of coverage.

Virtual Visits: covered Services received through virtual visits do not require Prior Authorization when provided through an HPN contracted Provider. Refer to the Attachment A, Benefit Schedule for the Member's Cost-share responsibility.

6.35 Gender Dysphoria

Covered Services for Gender Dysphoria, a disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association,* are provided if Prior Authorized and if the following diagnostic criteria are met:

For Adults and Adolescents:

- A marked incongruence between the Member's experienced/expressed gender and the Member's assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

For Children:

- A marked incongruence between the Member's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) and at least five of the following:
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

The following are Gender Dysphoria Covered Services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
- **Cross-sex hormone therapy** is available as follows**:**
  - Oral and injectable therapy, administered by a provider, during an office visit or in an outpatient or inpatient setting.
  - Oral and injectable therapy dispensed from a pharmacy as prescribed by a provider.

  Puberty suppressing medication is not cross-sex hormone therapy.
- **Laboratory Testing:** Benefit coverage includes laboratory testing to monitor continuous hormone replacement therapy provided as any other outpatient diagnostic service under the Plan.
- **Genital Surgery and Surgery to Change Secondary Sex Characteristics:** Provided as any other Medically Necessary service under this Plan (as appropriate to each patient) including:

  Male to Female:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:
  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

The Member must meet all of the following eligibility qualifications for genital surgery, surgery to change secondary sex characteristics and bilateral mastectomy or breast reduction surgery (in addition to the overall eligibility requirements in the EOC).

Breast Surgery:

The Member must provide documentation in the form of a written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Member meets all of the following criteria:

- Has persistent, well-documented Gender Dysphoria;
- Has the capacity to make a fully informed decision and to consent for treatment;
- Must be 18 years or older; and
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

Genital Surgery:

The Member must provide documentation in the form of a written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Member. The assessment must document that the Member meets all of the following criteria:

- Has persistent, well-documented Gender Dysphoria;
- Has the Capacity to make a fully informed decision and to consent for treatment;
- Must 18 years or older;
- If significant medical or mental health concerns are present, they must be reasonably well controlled;
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender; and
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

HPN makes no representation or warranty as to the medical competence or ability of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians. HPN shall have no liability or responsibility, either direct, indirect, vicarious or otherwise, or any actions or inactions, whether negligent or otherwise, on the part of any Gender Dysphoria Treatment Center/Facility or its respective staff or Physicians.

SECTION 7. Exclusions

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

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

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

7.3 Medical care received outside HPN's Service Area without Prior Authorization from HPN's Managed Care Program if the need for such services could reasonably have been foreseen prior to leaving HPN's Service Area.

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

7.5 Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

7.6 Any services provided before the Effective Date or after the termination of this Plan. This includes admission to an Inpatient facility when the admission began before the Effective Date or extended beyond the termination date of the Plan.

7.7 Services and supplies that are included in the basic hospital charges for room, board and nursing services. Housekeeping or meal services as part of Home Healthcare. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

7.8 Services for a private room when not Medically Necessary Services and charges in excess of the average semi-private room and board rate.

7.9 Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

7.10 Except as otherwise provide in the Attachment A Benefit Schedule, dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Treatment of pain or infection known or thought to be due to a dental condition and in close proximity to the teeth or jaw; surgical correction of malocclusion; maxillofacial orthognathic surgery, oral surgery (except as provided under the Covered Services Section), orthodontia treatment, pre-prosthetic surgery and any procedure involving osteotomy of the jaw, including outpatient Hospital or ambulatory surgical services, anesthesia and related costs when determined by HPN to relate to a dental condition.

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

7.11 Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function. Cosmetic procedures include:

- surgery for sagging or extra skin;
- any augmentation or reduction procedures;
- rhinoplasty and associated surgery; and
- any procedures utilizing an implant which does not alter physiologic functions unless Medically Necessary.

Psychological factors (example: for self-image, difficult social or peer relations) do not constitute restoring a physical bodily function and are not relevant to such determinations.

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

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

7.13 Powered and non-powered exoskeleton devices.

7.14 Any separate charges for anesthesia services associated with pain management procedures.

7.15 Services for the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and, except as provided in the Covered Services Gender Dysphoria section, implantation of a penile prosthesis.

7.16 Reversal of surgically performed sterilization or reversal of subsequent resterilization.

7.17 Elective abortions.

7.18 Amniocentesis, except when Medically Necessary under the guidelines of the American College of Obstetrics and Gynecology.

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

7.20 Venipuncture (drawing of blood for laboratory tests).

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

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

- Any and all services or supplies treatments, laboratory tests or x-rays received by the donor in connection with the transplant (including donor search, donor transportation, testing, registry and retrieval costs) and costs related to cadaver or animal retrieval or maintenance of a donor for such retrieval.

- Any and all Hospital, Physician, laboratory or x-ray services in any way related to any excluded transplant service, procedure or treatment.

7.23 Institutional care which is determined by HPN's Managed Care Program to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

7.24 Mental Health Services and Substance-Related and Addictive Disorder Services performed in connection with conditions not listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM)* or conditions listed as "Other Conditions" that may be of focus of clinical attention.

7.25 Outside of an initial assessment, Mental Health and Substance-Related and Addictive Disorder Services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7.26 Outside of an initial assessment, treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, personality disorders (with the exception of dialectical behavior therapy for borderline personality disorders) and paraphilic disorder.

7.27 Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7.28 Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

7.29 Outside of an initial assessment, unspecified disorders for which the provider is not obligated to provide the clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7.30 Neuropsychological testing when not required for the diagnosis of a Mental Illness, substance use disorder, or developmental disability.

7.31 Except as otherwise provide in the Attachment A Benefit Schedule, vision exams to determine refractive errors of vision and eyeglasses or contact lenses other than as specifically covered in this EOC. Coverage is provided for vision exams only when required to diagnose an Illness or Injury. Vision exams are not considered adult preventive care services.

7.32 Any prescription corrective lenses (eyeglasses or contact lenses) or frames following Post-Cataract Surgical Service which include, but are not limited to the following:

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

7.33 Coverage is provided for hearing exams only when required to diagnose an Illness or Injury. Hearing exams are not considered adult preventive care services.

7.34 Bone anchored hearing aids are excluded except when both of the following applies:

- The Member is not a candidate for an air-conduction hearing aid; and
- The bone-anchored hearing aid is used according to FDA approved indications.

Repairs and/or replacements for a bone anchored hearing aid, other than for malfunctions, are excluded for Member's who meet the above coverage criteria

7.35 Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian

dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile or gerovital.

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

7.37 Acupuncture or Hypnosis.

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

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

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

7.41 Services provided at a Free Standing Facility or diagnostic Hospital-based Facility without Prior Authorization through the HPN Managed Care Program. Services which are self-directed to a Free Standing Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Free Standing Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

- Has not been involved in your medical care prior to ordering the service, or
- Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography

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

7.43 Any equipment or supplies that condition the air. Arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace. Heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment. Incontinence supplies (diapers, pads, adult briefs) and bath aids (rails, shower chairs, bath benches).

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

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

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

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

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

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

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

7.51 Services performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on him/herself. Services performed by a Provider with the same legal address as the Member.

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

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

7.54 Telemetry readings, EKG interpretations when billed separately from the EKG procedure.

7.55 Arterial blood gas interpretations when billed separately from the procedure.

7.56 Services of more than one (1) assistant surgeon at one (1) operative session, unless approved in advance by HPN or its Medical Director. Service of an assistant surgeon when the Hospital provides or makes available qualified staff personnel (including Physicians in training status) as surgical assistants. Services of an assistant surgeon provided solely to meet a Hospital's institutional requirements when the complexity of the surgery does not warrant an assistant surgeon.

7.57 Autologous blood donations.

7.58 Covered services received in connection with a clinical trial or study, which includes the following:

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

7.59 Services provided by non-participating vision care providers.

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

7.61 Visual therapy.

7.62 Replacement of lost or stolen eyewear.

7.63 Two pairs of eyeglasses in lieu of bifocals.

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

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

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

7.67 Any services and supplies not provided for in the Evidence of Coverage, not Medically Necessary as defined by the Evidence of Coverage or not required in accordance with the accepted standards of dental practice of the community including:

- Services provided by non-participating dentists.
- Charges for services by a dental Plan Provider to his or her Dependents.
- Restorations using gold foil and any precious metal restoration when the tooth can be restored using other filling materials**.**
- Bonding for cosmetic purposes.
- Routine extractions for asymptomatic third (3rd) molar teeth.
- Routine extraction of loose deciduous teeth.

7.68 Services received in connection with Gender Dysphoria, which includes the following:

- Abdominoplasty;
- Blepharoplasty;

- Body contouring, such as lipoplasty;
- Breast enlargement, including augmentation mammoplasty and breast implants;
- Brow lift;
- Calf implants;
- Cheek, chin, and nose implants;
- Cryopreservation of fertilized embryos;
- Drugs for hair loss or growth;
- Face lift, forehead lift, or neck tightening;
- Facial bone remodeling for facial feminizations;
- Hair removal;
- Hair transplantation;
- Injection of fillers or neurotoxins;
- Lip augmentation;
- Lip reduction;
- Liposuction;
- Mastopexy;
- Pectoral implants for chest masculinization;
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- Rhinoplasty;
- Skin resurfacing;
- Sperm preservation in advance of hormone treatment or gender surgery;
- Surgical or hormone treatment on Members under eighteen (18) years of age;
- Surgical treatment not Prior Authorized by HPN;
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple);
- Transportation, meals, lodging or other similar expenses;
- Voice lessons and voice therapy; and
- Voice modification surgery.

7.69 Non-Medical 24-Hour Withdrawal Management.

7.70 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for experimental, investigational or unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan.

7.71 Drugs and medicine approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than one (1) year.

Pharmacy Specific Exclusions

7.72 Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7.73 Nutritional supplements, vitamins, herbal medicines, appetite suppressants, and over-the-counter drugs, except as specifically covered herein. Drugs and medicines approved by the FDA for experimental, investigational or unproven use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan. Any drug that has been approved by the FDA for less than one (1) year.

7.74 Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

7.75 Any product dispensed for the purpose of appetite suppression or weight loss.

7.76 Medications used for cosmetic purposes.

7.77 Prescription Drug Products when prescribed to treat infertility.

7.78 Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

7.79 Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.

7.80 Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the HPN EOC.

7.81 Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.

7.82 Prescription Drugs, including Covered Drugs, dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.

7.83 Drugs or supplies available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless HPN has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that HPN has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and HPN may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

7.84 General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.

7.85 Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.

7.86 Certain Prescription Drugs that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug.

7.87 Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Plan.

7.88 Any refill dispensed more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed.

7.89 Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.

7.90 Coverage for Prescription Drugs for the amount dispensed (days' supply, quantity limitation, dose, regimen, or frequency) which is less than or exceeds the supply limit.

7.91 Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to tier III or IV).

7.92 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.

7.93 Experimental or investigational or unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be experimental, investigational or unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.

7.94 A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and/or Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.

7.95 Prescription Drugs dispensed outside the United States, except as required for emergency treatment.

7.96 Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.

7.97 Biosimilar Prescription Drugs.

7.98 Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

7.99 Covered Drugs that are not FDA approved for a specific diagnosis.

7.100 Drugs and medicine approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than one (1) year.

7.101 Unit dose packaging and repackaging of Prescription Drugs.

SECTION 8. Limitations

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

8.1 Liability

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

- Natural disaster.
- War.
- Riot.
- Civil insurrection.
- Epidemic.
- Or any other emergency beyond HPN's control.

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

8.2 Calendar Year and Lifetime Maximum Benefit Limitations

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

8.3 Reimbursement

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

SECTION 9. Coordination of Benefits (COB)

This section tells you how other health insurance you may have affects your coverage under this Plan. NOTE: This plan is always secondary to a stand-alone dental plan for certain services pursuant to Nevada state regulations.

9.1 The Purpose of COB

Coordination of Benefits (COB) is intended to help contain the cost of providing healthcare coverage. When an individual person has dual coverage through HPN and another healthcare plan, the COB guidelines outlined in this Section apply. The COB guidelines explain how, in a dual healthcare coverage situation, benefits are coordinated or shared by each plan.

9.2 Benefits Subject to COB

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

9.3 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.4 When COB Applies

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

9.5 Determination Rules

The rules establishing the order of benefit determination are:

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

(b) **Dependent Child of Parents Not Separated or Divorced**. Except as stated in 10.5(c) below, when this Plan and another Plan cover the same child as a Dependent of different parents:

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

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

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

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

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

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

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

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

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

9.6 How COB Works

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

9.7 Right to Receive and Release Information

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

9.8 Facility of Payment

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

9.9 Right to Recover Payment

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

9.10 Failure to Cooperate

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

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

SECTION 10. Subrogation

If a Member's Illness or Injury is caused by a third party, and the Member has the right to recover damages from that third party, HPN will provide or make payment for Covered Services related to such Illness or Injury. Acceptance of such Covered Services or payment shall constitute consent to the provisions of this section.

10.1 Member Reimbursement Obligation

If a Member receives payment for medical services and supplies from a third party through a suit or settlement, the Member will be obligated to reimburse HPN for either the actual cost incurred by HPN or the reasonable value of services for benefits provided under this Plan for such services and supplies, but no more than the amount the Member recovers.

10.2 HPN's Right of Recovery

HPN shall place a lien on all funds recovered by the Member either the actual cost incurred by HPN or the reasonable value for the services and supplies provided to the Member. HPN may give notice of that lien to any party who may have contributed to the loss.

HPN has the right to be subrogated to the Member's rights to the extent of the benefits payable for Covered Services received under this Plan. This includes HPN's right to bring suit against a third party in the Member's name.

10.3 Member Cooperation

The Member must take such action, furnish such information and assistance, and execute such instruments as HPN may require to facilitate enforcement of its rights under this provision. The Member shall take no action prejudicing the rights and interests of HPN under this provision.

Any Member who fails to cooperate in HPN's administration of this section shall be responsible for the actual cost of the services rendered in connection with the Illness or Injury caused by a third party.

SECTION 11. General Provisions

11.1 Relationship of Parties

The relationship between HPN and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of HPN; nor is HPN, or any employee of HPN, an employee or agent of a Plan Provider. HPN is not liable for any claim or demand on account of damages as a result of, or in any manner connected with, any Injury suffered by a Member while receiving care from any Plan Provider or in any Plan Provider's facility. HPN is not bound by statements or promises made by its Plan Providers.

11.2 Entire Agreement

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

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

In the event HPN decides to discontinue offering and renewing health benefit plans delivered or issued for delivery in this state, HPN will provide notice of its intention to all persons covered by the discontinued insurance at least ninety (90) days before the nonrenewal of any health benefit plan by HPN.

11.3 Payment of Benefits

Payment of benefits by HPN shall be in cash or cash equivalents, or in a form of other consideration that HPN determines to be adequate. Where benefits are payable directly to a Provider, such adequate consideration includes the forgiveness in whole or in part

of the amount the Provider owes to HPN, or to other Health Benefit Plans' for which HPN makes payments where HPN has taken an assignment of the other plans' recovery rights for value.

11.4 Contestability

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

11.5 Authority to Change the Form or Content of this Plan

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

11.6 Identification Card

Cards issued by HPN to Members are for identification only. Possession of an HPN identification card does not give the holder any right to services or other benefits under this Plan.

To be entitled to such services or benefits, the holder of the card must in fact be a Member and all applicable premiums must actually have been paid. Any person not entitled to receive services or other benefits will be liable for the actual cost of such services or benefits.

11.7 Notice

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

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

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

11.8 Interpretation of the EOC

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

11.9 Assignment

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

11.10 Modifications

The Group makes HPN coverage available under this Plan to individuals who are eligible under Section 1. However, this Plan is subject to amendment, modification or termination with sixty (60) days written notice to the Group without the consent or concurrence of the Members.

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

11.11 Clerical Error

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

11.12 Policies and Procedures

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

11.13 Overpayments

If HPN pays benefits for expenses incurred on account of an enrolled Member, that Member or any other person or organization that was paid, must make a refund to HPN if any of the following apply:

- If the refund is due from the Member and the Member does not promptly refund the full amount, HPN may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for the Member that are payable under the policy. If the refund is due from a person or organization other than the Member, HPN may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part;
    - future benefits that are payable in connection with services provided to other Members under the policy; or
    - future benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which HPNs overpayment recovery rights are assigned to such other Health Benefit Plan's in exchange for such Plans' remittance of the amount of the reallocated payment.

11.14 Cost Containment Features

This Plan contains at least the following cost containment provisions including, but not limited to:
(a) Preventive healthcare benefits.
(b) The Managed Care Program.
(c) Benefit limitations on certain services.
(d) Member Cost-share.

11.15 Release of Records

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

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

11.16 Reimbursement for Claims

Non-Plan Providers may require immediate payment for their services and supplies. When seeking reimbursement from HPN for expenses incurred in connection with services received from Non-Plan Providers, the Member must complete a Non-Plan Provider Claim Form and submit it to the HPN Claims Department with copies of all of the medical records, bills and/or receipts from the Provider. Non-Plan Provider Claim Forms can be obtained by calling the Member Services Department at 1-800-777-1840.

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

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

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

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

11.17 Timely Filing Requirement

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

directly if payment directly to the Provider is not authorized. The Member will receive an explanation of how the payment was determined.

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

11.18 Gender References

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

11.19 Legal Proceedings

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

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

11.20 Availability of Providers

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

11.21 Physician Incentive Plan Disclosure

You are entitled to ask if HPN has special financial arrangements with their contracted Physicians that may affect Referral services, such as lab tests and hospitalizations that you might need. To receive information regarding contracted Physician payment arrangements, please call the Member Services Department at the number listed on page 3 of this EOC. This information will be sent to you within thirty (30) days of the date that you make your request.

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

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

11.22 Provisions Deemed to be in Compliance for National Accounts

This Plan meets the requirements for a Federally Qualified HMO for only` those Groups defined as National Accounts. For the purposes of this Plan, a National Account is defined as a company with a principal office located outside the state of Nevada, with employees located in multiple states, to include Nevada. With respect to National Accounts, provisions of the HPN EOC that are determined by the appropriate regulatory agency not to be in compliance or agreement with applicable regulations for Federally Qualified HMOs, are hereby amended in accordance with such requirements.

11.23 Authorized Representative

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

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

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

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

11.24 Failure to Obtain Prior Authorization

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

11.25 Timing of Notification of Benefit Determination

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

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

11.26 Notification of an Adverse Benefit Determination

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

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

11.27 Prior Healthcare Coverage

If the Member has prior coverage that, as required by state law, extends benefits for a particular condition or a disability, HPN will not pay benefits for health care services for that condition or disability until the prior coverage ends. HPN will pay benefits as of the day coverage begins under the Plan for all other Covered Services that are not related to the condition or disability for which the Member has other coverage.

SECTION 12. Pharmacy Provisions

12.1 Obtaining Covered Drugs

Benefits for Covered Drugs are payable subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided herein.
- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.

- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable tier Copayment and/or Coinsurance for up to a 30 day supply. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom HPN has an arrangement to provide those Covered Drugs. If you choose not to use the Designated Plan Pharmacy and instead have the Specialty Covered Drugs dispensed by a non-Designated Plan Retail Pharmacy, you will be responsible for paying the two times amount of the Specialty Covered Drug Tier cost-share as stated in the applicable plan Attachment A, Schedule of Benefits.
- When a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive thirty (30) day supply, the Cost-share that applies will reflect the number of days dispensed.

12.2 Designated Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Member obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement.

- **Tier I –** is the low Cost-share option for Covered Drugs.
- **Tier II –** is the midrange Cost-share option for Covered Drugs.
- **Tier III –** is the high Cost-share option for Covered Drugs.
- **Tier IV –** is the highest Cost-share option for Covered Drugs.
- **Mandatory Generic benefit provision applies when:**
  - a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. After satisfying any applicable CYD, the Member will pay the applicable tier Copayment and/or Coinsurance plus the difference between the Eligible Medical Expenses ("EME") of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply. The difference in the amount between such Brand Name and Generic Covered Drug paid by the Member does not accumulate to any otherwise applicable plan Calendar Year Prescription Drug Deductible, overall plan CYD or annual Out of Pocket Maximum.

When a Drug is dispensed through the Mail Order Plan Pharmacy, benefits are subject to the applicable tier Copayment and/or Coinsurance per Mail Order Therapeutic Supply.

12.3 Emergency or Urgently Needed Services Prescription Drugs

Dispensed by a Plan Pharmacy. When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the Cost-share amount subject to the applicable tier benefit.

Dispensed by a Non-Plan Pharmacy. When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Non-Plan Pharmacy at the time the Covered Drug is dispensed, the full cost of the Covered Drug subject to the Non-Plan Pharmacy Benefits Payment subsection.

12.4 Non-Plan Pharmacy Benefit Payments

In order for claims for Covered Drugs obtained at a Non-Plan Pharmacy to be eligible for benefit payment, the Member must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to HPN or its designee.

Benefit payments are subject to the limitations and exclusions set forth in the HPN EOC as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's EME and any applicable tier Copayment and/or Coinsurance. The Member is responsible for any amounts exceeding HPN's benefit payment.
2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to HPN's EME of the Generic Covered Drug less the applicable tier Copayment and/or Coinsurance. The Member is responsible for any amounts exceeding HPN's benefit payment.
3. No benefits are payable if HPN's EME of the Covered Drug is less than the applicable Copayment and/or Coinsurance.

12.5 90 Day Retail Plan Network [(1)] and Mail Order Plan Pharmacy Benefit Payments

Benefits for Covered Drugs are available when dispensed by an HPN Retail[(1)] and Mail Order Plan Pharmacy subject to the applicable tier Copayment. Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

[(1)] Applies to select retail pharmacies, please consult your Provider directory.

12.6 Limitations

- Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- Benefits are available for refills of Covered Drugs, including prescription eye drops and opioids, only when dispensed as ordered by a duly licensed health care provider. Refills are provided once a given amount of the Covered Drug is used through the course of therapy; amounts vary by the type of Covered Drug. Refill dates of Covered Drugs can be aligned so that drugs that are refilled at the same frequency can be refilled concurrently.
- A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.
- Benefits for prescriptions for Mail Order Drugs submitted following HPN's receipt of notice of Member's termination will be limited to the appropriate Therapeutic Supply from the date such notice of termination is received to the Effective Date of termination of the Member.
- Benefits are not payable if the Member is directed to a Designated Plan Pharmacy and chooses not to obtain the Covered Drug from that Designated Plan Pharmacy.
- If HPN determines that the Member may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Member's selection of Plan Pharmacies may be limited. If this happens, HPN may require the Member to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if the Member uses the assigned single Plan Pharmacy. If a selection is not made by the Member within thirty-one (31) days of the date of notification, then HPN will select a single Plan Pharmacy for the Member.
- Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in fifteen (15) day supplies up to ninety (90) days and at a pro-rated Copayment or Coinsurance. The Member will receive a fifteen (15) day supply of the Specialty Prescription Drug Product to determine if the Member will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Member each time prior to dispensing the fifteen (15) day supply to confirm if the Member is tolerating the Specialty Prescription Drug Product. The list of these certain Specialty Prescription Drugs is available through review of the HPN Prescription Drug List (PDL).
- If a Prescription Drug is excluded from coverage, the Member or representative may request an exception to gain access to the excluded Prescription Drug. Exceptions do not apply to drugs that are considered benefit exclusions, such as drugs for sexual dysfunction, cosmetic products and infertility.

  To make a request, contact HPN in writing or call the toll-free number on your ID card. Please note, if the request for an exception is approved by HPN, the Member may incur the cost of the excepted Prescription Drug at the highest tier. If the request requires immediate action and a delay could significantly increase a health risk or the ability regain maximum function, call HPN as soon as possible. HPN will provide a written or electronic determination within twenty-four (24) hours. If the Member is not satisfied with HPN determination of the exclusion exception, they may request an External Review. Please refer to the *Appeals Procedure* section herein for further information.

- HPN may have certain programs in which the Member may receive an enhanced or reduced benefit based on their actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. Questions about these programs can be directed to the Member Services telephone number on your ID card.

12.7 Coverage Policies and Guidelines

HPNs Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on HPN's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug's acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above but only at times specified by NRS 687B.4095 . As a result of such changes, you may be required to pay more or less for that Prescription Drug.

Questions about HPN's PDL should be directed to the Member Services Department at 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at http://healthplanofnevada.com/~/media/Files/HPN/pdf/Forms/OptumRx-Reimbursement.ashx?la=en.

Coupons
HPN may not permit certain coupons or offers from pharmaceutical manufacturers or their affiliates to apply to the Member's annual CYD and/or Out of Pocket Maximum or to reduce the Member's Copayments and/or Coinsurance. Costs defrayed for the Member as a result of pharmaceutical coupons are not Eligible Expenses. Questions regarding which coupons or offers are available can be addressed at healthplanofnevada.com.

Rebates and Other Payments
HPN may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that a Member purchased prior to meeting any applicable deductible. As determined by HPN, a portion of any rebates may be passed on to the Member and may be taken into account in determining any applicable Copayment and/or Cost-share.

HPN, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from the Outpatient Prescription Drug benefit. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug benefit and, therefore, such amounts do not pass on to the Member.

SECTION 13. Appeals Procedures

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

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

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

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

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

Informal Review: An Adverse Benefit Determination or medical site service complaint/concern which is directed to the HPN Member Services Department via phone or in person. If an Informal Review is resolved to the satisfaction of the Member, the matter ends. The Informal Review is **voluntary**.

1st Level Formal Appeal: An appeal of an Adverse Benefit Determination filed either orally or in writing which HPN's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The 1st Level Formal Appeal is **mandatory** if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

2nd Level Formal Appeal: If a 1st Level Formal Appeal is not resolved to the Member's satisfaction, a Member may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted either orally or in writing and reviewed by the Grievance Review Committee. The 2nd Level Formal Appeal is **voluntary** for ~~all~~ Adverse Benefit Determinations. Appeals that meet expedite criteria are not eligible for 2nd Level Formal Appeal and may be processed through the Expedited External Review process.

Grievance Review Committee: A committee in which the majority of those individuals who are voting members must be members of an HPN Health Benefit Plan.

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

13.1 Informal Review

A Member who has received an Adverse Benefit Determination of a Claim for Benefits may request an Informal Review. All Informal Reviews must be made to HPN's Member Services Department within 180 days of the Adverse Benefit Determination. Informal Reviews not filed in a timely manner will be deemed waived. The Informal Review is a **voluntary** level of appeal.

Upon the initiation of an Informal Review, a Member must provide Member Services with at least the following information:

- The Member's name (or name of Member and Member's Authorized representative), address, and telephone number;
- The Member's HPN membership number and Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

The Member Services Representative will inform the Member that upon review and investigation of the relevant information, HPN will make a determination of the Informal Review. The determination will be made as soon as reasonably possible but will not exceed thirty (30) days unless more time is required for fact-finding. If the determination of the Informal Review is not acceptable to the Member and the Member wishes to pursue the matter further, the Member may file a 1st Level Formal Appeal.

13.2 1st Level Formal Appeal

When an Informal Review is not resolved in a manner that is satisfactory to the Member or when the Member chooses not to file an Informal Review and the Member wishes to pursue the matter further, the Member must file a 1st Level Formal Appeal. The 1st Level Formal Appeal must be submitted orally or in writing to HPN's Customer Response and Resolution Department within 180 days of an Adverse Benefit Determination. Such 180 days will run concurrently with the 180 day time period applicable to an Informal Review as set forth herein. NOTE: 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

The 1st Level Formal Appeal shall contain at least the following information:

- The Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;
- The Member's HPN membership number and Group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

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

The 1st Level Formal Appeals should be sent or faxed to the following:

Health Plan of Nevada, Inc.
Attn: Customer Response and Resolution Department
PO Box 14865
Las Vegas, NV 89114

HPN will investigate the appeal. When the investigation is complete, the Member will be informed in writing of the resolution within thirty (30) days of receipt of the request for the 1st Level Formal Appeal. This period may be extended one (1) time by HPN for up to fifteen (15) days, provided that the extension is necessary due

- to matters beyond the control of HPN and
- HPN notifies the Member prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the date by which HPN expects to render a decision. If the extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Member shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

If HPN is unable to resolve the Members appeal as additional information is required, HPN will contact the Member to obtain their permission to withdraw the appeal. The Member will receive written notification that the appeal has been withdrawn and advise of the ninety (90) day timeframe in which to reopen their appeal.

If the 1st Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits;

- A statement describing any voluntary appeal procedures offered by HPN and the Member's right to receive additional information describing such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable;
- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or experimental, investigational or unproven treatment or similar exclusion or limit, either
    - an explanation of the scientific or clinical judgment or
    - a statement that such explanation will be provided free of charge as well as information regarding the Member's right to request an External Review by the State of Nevada's Office for Consumer Health Assistance (OCHA).

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

If the resolution to the 1st Level Formal Appeal is not acceptable to the Member and the Member wishes to pursue the matter further, the Member is entitled to file a 2nd Level Formal Appeal. The Member will be informed of this right at the time the Member is informed of the resolution of his 1st Level Formal Appeal.

13.3 Expedited Appeal – 1st Level Formal Appeal

The Member can ask (either orally or in writing) for an Expedited Appeal of an Adverse Benefit Determination for a Pre-Service Claim that involves an Urgent Care Claim if the Member or his Physician believe that the health of the Member could be seriously harmed by waiting for a routine appeal decision. Expedited Appeals are not available for appeals regarding denied claims for benefit payment (Post-Service Claim) or for Pre-Service Claims that are not Urgent Care Claims. Expedited Appeals must be decided no later than seventy-two (72) hours after receipt of the appeal, provided all necessary information has been submitted to HPN. If the initial notification was oral, HPN shall provide a written or electronic explanation to the Member within seventy-two (72) hours after the expedited appeal being filed.

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

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

If the Member's Physician

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

HPN will automatically grant an Expedited Appeal.

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

13.4 2nd Level Formal Appeal

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the Member, the Member may initiate a 2nd Level Formal Appeal. This appeal must be submitted orally or in writing within thirty (30) days after the Member has been informed of the resolution of the 1st Level Formal Appeal.

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filing a 2nd Level Formal Appeal. A 2nd Level Formal Appeal not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which it relates. The 2nd Level Formal Appeal is **voluntary** for all Pre-Service and Post-Service Claims for Benefits.

Expedited appeals are not eligible for 2nd Level Formal Appeal. Expedited appeals may be processed through the Expedited External Review process. Please reference Expedited External Review of this plan document.

The notice to the Member or the Member's Authorized Representative will also include

- a HIPAA compliant authorization form by which the Member or the Member's Authorized Representative can authorize HPN and the Member's Physician to disclose protected health information ("PHI"), including medical records, that are pertinent to the 2nd Level Formal Appeal and
- any other forms as required by Nevada law or regulation.

The Member shall be entitled to the same reasonable access to copies of documents referenced above under the 1st Level Formal Appeal. Any new or additional information considered, relied upon or generated by the Plan will be provided to the Member, free of charge and in advance of the date on which the notice of the final internal adverse determination is required, in order to give the Member a reasonable opportunity to respond prior to this date.

The Member can request the assistance of a Member Services Representative at any time during this process.

Upon request, the Member is entitled to present telephonically and provide a formal presentation on a 2nd Level Formal Appeal. If such a hearing is requested, HPN shall make every reasonable effort to schedule a mutually convenient time for the parties involved. Repeated refusal on the part of the Member to cooperate in the scheduling of the formal presentation shall relieve the Grievance Review Committee of the responsibility of hearing a formal presentation, but not of reviewing the 2nd Level Formal Appeal. If a formal presentation is held, the Member will be permitted to provide documents to the Grievance Review Committee and to have assistance in presenting the matter to the Grievance Review Committee, including representation by counsel. However, HPN must be notified at least five (5) business days before the date of the scheduled formal presentation of the Member's intent to be represented by counsel and/or to have others present during the formal presentation. Additionally, the Member must provide HPN with copies of all documents the Member may use at the formal presentation five (5) business days before the date of the scheduled formal presentation. Upon HPN's receipt of the written request, the request will be forwarded to the Grievance Review Committee along with all available documentation relating to the appeal.

The Grievance Review Committee shall:

- consider the 2nd Level of Appeal;
- schedule and conduct a formal presentation if applicable;
- obtain additional information from the Member and/or staff as it deems appropriate; and
- make a decision and communicate its decision to the Member within thirty (30) days following HPN's receipt of the request for a 2nd Level Formal Appeal.

If the resolution of the 2nd Level Formal Appeal results in an Adverse Benefit Determination, the Member will be informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the benefit determination is based; and
- A statement describing any additional voluntary levels of appeal.
- A statement describing the Member's External Appeals Rights, if applicable, or judicial review.

Limited extensions may be required if additional information is required or a formal presentation is requested and the Member agrees to the extension of time.

13.5 External Review

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

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

> *HPN has denied your request for the provision or payment of a requested healthcare service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for External Review to the Office for Consumer Health Assistance (OCHA).*

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

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

The notice to the Member or the Member's Authorized Representative will also include:

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

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

Address	Telephone Number(s)	Website
Office for Consumer Health Assistance	(702) 486-3587	www.CHA@govcha.nv.gov
3320 W. Sahara Ave., Suite 100	(888) 333-1597	
Las Vegas NV 89102	Fax: (702) 486-3586	

The determination of an IRO concerning an External Review in favor of the Member of an adverse determination is final, conclusive and binding. If your plan is governed by Employee Retirement Income and Security Act (ERISA), you may have the right to file a civil action under ERISA if all required mandatory reviews of your claim have been completed. Upon receipt of the notice of a decision by the IRO reversing an adverse determination, HPN shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination. The cost of conducting an External Review of an adverse determination will be paid by HPN.

13.6 Standard External Review

The Member may submit a request for an External Review of an adverse determination under this section only after

- the Member has exhausted all applicable internal HPN Appeals Procedures provided under this Plan or
- if HPN fails to issue a written decision to the Member within thirty (30) days after the date the Appeal was filed, and the Member or Member's Authorized Representative did not request or agree to a delay or,
- if HPN agrees to permit the Member to submit the adverse determination to OCHA without requiring the Member to exhaust all internal HPN Appeals Procedures.

In such event, the Member shall be considered to have exhausted the applicable internal HPN Appeals Process.

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

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

- Any medical records of the Member relating to the adverse determination;
- A copy of the provisions of the healthcare Plan upon which the adverse determination was based;
- Any documents used and the reason(s) given by HPN's Managed Care Program for the adverse determination; and
- If applicable, a list that specifies each Provider who provided healthcare to the Member and the corresponding medical records from the Provider relating to the adverse determination.

Within five (5) days after the IRO receives the required documentation from HPN, they shall notify the Member or the Member's Authorized Representative, if any additional information is required to conduct the review. If additional information is required, it must be provided to the IRO within five (5) days after receiving the request. The IRO will forward a copy of the additional information to HPN within one (1) business day after receipt.

The IRO shall approve, modify, or reverse the adverse determination within fifteen (15) days after it receives the information required to make such a determination. The IRO shall submit a copy of its determination, including the basis thereof, to the:

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

13.7 Expedited External Review

A request for an Expedited External Review may be submitted to OCHA when the mandatory 1st Level Appeal has been exhausted and after it receives proof from the Member's Provider that the adverse determination concerns:

- An inpatient admission;
- availability of inpatient care;
- continued stay or health care service for Emergency Services while still admitted to an inpatient facility; or
- failure to proceed in an expedited manner may jeopardize the life or health of the Member.

The OCHA shall approve or deny this request for Expedited External Review within seventy-two (72) hours after receipt of the above required proof. If OCHA approves the request, it shall assign the request to an IRO no later than one (1) business day after approving the request. HPN will supply all relevant medical documents and information used to establish the adverse determination to the IRO within twenty-four (24) hours after receiving notice from the OCHA.

The IRO shall complete its Expedited External Review within forty-eight (48) hours after initially being assigned the case unless the Member or the Member's Authorized Representative and HPN agree to a longer time period.

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

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

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

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

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

13.9 Standard External Review

The Member or Member's Authorized Representative may within four (4) months after receiving notice of an adverse determination subject to this section, submit a request to the OCHA for an External Review. All requests for standard external review must be made in writing to the Office for Consumer Health Assistance.

OCHA will notify HPN and/or any other interested parties within one (1) business day after the receipt of the request for External Review. Within five (5) business days after HPN receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, HPN will make a preliminary determination of whether the case is complete and eligible for External Review.

Within one (1) business day of making such a determination, HPN will notify in writing, the Member or the Member's Authorized Representative and OCHA, accordingly. If HPN determines that the case is incomplete and/or ineligible, HPN will notify the Member in writing of such determination. Such notice shall include the required additional information or materials needed to make the request complete and, if applicable, state the reasons for ineligibility and also state that such determination may be appealed to OCHA. Upon appeal, OCHA may overturn HPN's determination that a request for External Review of an adverse determination is ineligible, and submit the request to External Review, subject to all of the terms and provisions of this Plan and applicable Nevada law and regulation.

Within one (1) business day after receiving the confirmation of eligibility for External Review from HPN, OCHA will assign the IRO accordingly and notify in writing the Member or the Member's Authorized Representative and HPN that the request is complete and eligible for External Review and provide the name of the assigned IRO. HPN, within five (5) days after receipt of such notice from

the OCHA, will supply all relevant medical documents and information used to establish the adverse determination to the assigned IRO who will select and assign one or more clinical reviewers to the External Review.

The IRO shall approve, modify, or reverse the adverse determination pursuant to this section within twenty (20) days after it receives the information required to make such a determination.

The Independent Review Organization shall submit a copy of its determination, including the basis thereof, to the:
- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

13.10 Expedited External Review

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

An oral request for an Expedited External Review may be submitted directly to the OCHA upon the written submission of proof from the Member's Provider to OCHA. Upon receipt of such request and proof, OCHA shall immediately notify HPN accordingly.

HPN will immediately determine if the request meets the requirements for Expedited External Review pursuant to this section and notify the Member or the Member's Authorized Representative and the OCHA of the determination. If HPN determines the request to be ineligible, the Member will be notified that the request may be appealed to OCHA.

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

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

The clinical reviewers have no more than five (5) days to provide an opinion to the IRO. The IRO has forty-eight (48) hours to review the opinion of the clinical reviewers and make a determination.

The IRO shall notify the following parties no later than twenty-four (24) hours after completing its External Review:
- Member;
- Member's Physician;
- Member's Authorized Representative, if any; and
- HPN.

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

13.11 Office for Consumer Health Assistance

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

SECTION 14. Glossary

❖ "**Adverse Benefit Determination**" means a rescission of coverage; a decision by HPN to deny, reduce, terminate, fail to provide, or make payment for a benefit, including a denial, reduction termination, or failure to provide, or make a payment for a benefit that is based on:
- an individual's eligibility;

- a determination that a benefit is not a Covered Service;
- the imposition of a limitation of an otherwise Covered Service; or
- a determination that a benefit is experimental, investigational or unproven, or not Medically Necessary or appropriate.

External Review is only available for a Final Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service. An Adverse Benefit Determination is final if the Member has exhausted all complaint and Appeal Procedures set forth herein for the review of such Adverse Benefit Determination.

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

❖ "**Ambulatory Surgical Facility**" means a facility that:
- Is licensed by the state where it is located.
- Is equipped and operated mainly to provide for surgeries or obstetrical deliveries.
- Allows patients to leave the facility the same day the surgery or delivery occurs.

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

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

❖ **"Autism Spectrum Disorders"** means a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.

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

❖ **"Biosimilar Prescription Drug"** means a biological Prescription Drug approved based on showing that it is highly similar to a Reference Product, and has no clinically meaningful differences in terms of safety and effectiveness from the Reference Product.

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

❖ **" Brand Name Drug"** means a Prescription Drug which is marketed under or protected by:
- a registered trademark; or
- a registered trade name; or
- a registered patent.

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

❖ **"Calendar Year Out of Pocket Maximum**" means the maximum amount of Out of Pocket expenses a Member is required to pay for Covered Services in a Calendar Year, as outlined in the Attachment A, Schedule of Benefits. Once the Calendar Year Out of Pocket Maximum is met, no further cost share is required for the remainder of the Calendar Year. For purposes of accumulating benefits paid toward any applicable benefit maximums under the Plan, the period of such accumulation will coincide with the time period of the Calendar Year applicable to the Group.

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

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

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

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

- **"Coinsurance"** means the percentage of the charges billed or the percentage of Eligible Medical Expenses, whichever is less, that a Member must pay a Provider for Covered Services. Coinsurance amounts are to be paid by the Member directly to the Provider who bills for the Covered Services. (See Attachment A, Benefit Schedule.)

- **"Compound"** means to form or create a Medically Necessary customized composite product by combining two (2) or more different ingredients according to a Physician's specifications to meet an individual patient's need.

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

- "**Contract Year**" means the twelve (12) months beginning with and following the Effective Date of the Group Enrollment Agreement (GEA).

- **"Convenient Care Facility"** means a facility that provides services for Medically Necessary, non-urgent or non-emergent injuries or illnesses. Examples of such conditions include:
  1. blood pressure checks;
  2. diagnostic laboratory services;
  3. general health screenings;
  4. minor illnesses (cold/flu);
  5. minor wound treatment and repair;
  6. treatment of burns and sprains.

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

- **"Covered Drug"** means a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:
  - can only be obtained with a prescription;
  - has been approved by the Food and Drug Administration ("FDA") for general marketing;
  - is dispensed by a licensed pharmacist;
  - is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
  - is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
  - is not specifically excluded herein.

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

- "**Covered Transplant Procedure**" means any Medically Necessary, human-to-human, organ or tissue transplants performed upon a Member who satisfies medical criteria developed by HPN for receiving transplant services.

- "**Custodial Care**" means care that mainly provides room and board (meals) for a physically or mentally disabled person. Such care does not reduce the disability so that the person can live outside a Hospital or nursing home. Examples of Custodial Care include:
  - Non-Skilled Nursing Care.
  - Supervisory care by a Physician in a custodial facility to meet regulatory requirements.
  - Training or assistance in personal hygiene.
  - Other forms of self-care.

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

- **"Dentist"** means anyone qualified and licensed to practice dentistry who has a degree of Doctor or Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).

❖ **"Dental Director"** means a Dentist designated by HPN to review the utilization of dental services by Members.

❖ "**Dependent**" means an Eligible Family Member of the Subscriber's family who:
- meets the eligibility requirements of the Plan as set forth in Section 1 of this EOC;
- is enrolled under this Plan; and
- for whom premiums have been received and accepted by HPN.

❖ **"Designated Plan Pharmacy"** means a pharmacy that has entered into an agreement with HPN to provide specific Covered Drugs and/or supplies to Members. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit, please refer to the HPN PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for your Covered Drug and/or supply/equipment.

❖ **"Dispensing Period"** as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Member that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.

❖ "**Durable Medical Equipment**" or "**DME**" means medical equipment that:
- can withstand repeated use;
- is used primarily and customarily for a medical purpose rather than convenience or comfort;
- generally is not useful to a person in the absence of an Illness or Injury;
- is appropriate for use in the home; and
- is prescribed by a Physician.

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

❖ "**Eligible Dental Expenses", "Eligible Medical Expenses**", **"Eligible Vision Expenses"** or **"EDE", "EME", "EVE",** respectively means the maximum amount HPN will pay for a particular Covered Service as determined by HPN in accordance with HPN's Reimbursement Schedule.

❖ "**Eligible Employee**" means a natural person that meets the following criteria:
- Is employed full-time;
- Is in an active employment status;
- Works at least the minimum number of hours per week indicated by the Group in the Attachment A to the GEA (typically 30 hours);
- Meets the applicable waiting period indicated by the Group in the Attachment A to the GEA;
- Enrolls during an enrollment period;
- Lives or work in HPN's Service Area; and
- Works for an employer that meets the minimum employer contribution percentage for the applicable coverage as set forth in the Attachment A to the GEA.

The term includes a sole proprietor or a partner of a partnership, if the sole proprietor or partner is included as an Eligible Employee under a Health Benefit Plan of a Small Employer.

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

❖ **"Emergency Dental Services"** means Covered Services provided after the sudden onset of a dental condition involving the teeth and supporting tissues with symptoms severe enough to cause a prudent person to believe that there is an immediate need to be treated by a relevant professional.

❖ "**Emergency Services**" means Covered Services provided after the sudden onset of a medical or dental condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious:
- jeopardy to his health;
- jeopardy to the health of an unborn child;
- impairment of a bodily function; or
- dysfunction of any bodily organ or part.

- "**Enrollment Date**" means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period. If an individual receiving benefits under the employer's Health Benefit Plan changes benefit packages, or if the employer changes Health Benefit Plan carriers, the individual's Enrollment Date does not change.

- "**ERISA**" means Employee Retirement Income Security Act of 1974, as amended, including regulations implementing the Act.

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

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

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

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

- "**External Review**" means an independent review of an Adverse Benefit Determination conducted by an Independent Review Organization.

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

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

- **"Frames"** means standard eyeglass Frames adequate to hold two lenses.

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

- **"Free Standing Emergency Facility"** means a facility, structurally separate and distinct from a hospital, which provides limited services for the treatment of a medical emergency and licensed as ascribed in NAC 449.61032 – NAC 449.61384.

- **"Full-time Employee"** means an employee who works an average of at least 30 hours of service per week or 130 hours of service per month.

- **"Gender Dysphoria"** means a disorder characterized by diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

- **"Generic Drug"** means an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.

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

- "**Group**" means an employer or legal entity that has completed and signed the Group Enrollment Agreement and the Attachment A to the Group Enrollment Agreement (Group Application) with HPN for HPN to provide Covered Services.

❖ "**Group Enrollment Agreement**" or "**GEA**" means the agreement signed by HPN and Group that states the conditions for coverage, eligibility and enrollment requirements and premiums.

For a sole proprietor to qualify for small group coverage, the business must have at least one employee who is not the owner or the owner's spouse.

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

- Coverage for accident only, dental only, vision only, disability income insurance, long-term care only insurance, hospital indemnity coverage or other fixed indemnity coverage, limited benefit coverage, specific disease/Illness coverage, credit-only insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation insurance;
- Coverage for medical payments under a policy of automobile insurance;
- Coverage for on-site medical clinics; or
- Medicare supplemental health insurance.

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

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

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

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

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

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

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

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

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

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

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

Hospital does not include:

- Ambulatory Surgical Facilities
- Christian Science sanataria;
- Free Standing Emergency Facilities;
- health resorts;
- institutions for exceptional children;
- nursing homes;
- Residential Treatment Centers;
- Physician offices;
- private homes; or
- Skilled Nursing Facilities, places that are primarily for the care of convalescents.

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

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

❖ "**Initial Enrollment Period**" means the period of time during which an eligible person may enroll under this Plan, as shown in the GEA signed by the Group.

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

❖ "**Inpatient**" means being confined in a Hospital, Skilled Nursing Facility or Residential Treatment Center as a registered bed patient under a Physician's order.

❖ **"Lenses"** means ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Vision Provider to be fitted into frames.

❖ **"Licensed Assistant Behavior Analyst"** means a person who holds current certification as a Board Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

❖ **"Licensed Behavior Analyst"** means a person who holds current certification as a Board Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services.

❖ **"Low Vision"** means a significant loss of vision but not total blindness.

❖ **"Mail Order Plan Pharmacy"** means a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Covered Drugs to Members by mail.

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

❖ "**Manual Manipulation**" means the diagnosis, treatment or maintenance by a Practitioner for the treatment of:
- musculoskeletal strain surrounding vertebra, spine, broken neck; or

- subluxation of vertebra.

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

❖ "**Medical Director**" means a Physician named by HPN to review use of health services by Members.

❖ "**Medically Necessary**" means a service or supply needed to improve a specific health condition or to preserve the Member's health and which, as determined by HPN is:

- consistent with the diagnosis and treatment of the Member's Illness or Injury;
- the most appropriate level of service which can be safely provided to the Member; and
- not solely for the convenience of the Member, the Provider(s) or Hospital.

In determining whether a service or supply is Medically Necessary, HPN may give consideration to any or all of the following:

- the likelihood of a certain service or supply producing a significant positive outcome;
- reports in peer-review literature;
- evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data;
- professional standards of safety and effectiveness that are generally recognized in the United States for diagnosis, care or treatment;
- the opinions of independent expert Physicians in the health specialty involved when such opinions are based on broad professional consensus; or
- other relevant information obtained by HPN.

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

❖ "**Medically Necessary for External Review**" means healthcare services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Illness, Injury or disease or any symptoms thereof that are necessary and:

- provided in accordance with generally accepted standards of medical practice;
- clinically appropriate with regard to type, frequency, extent, location and duration;
- not primarily provided for the convenience of the patient, Physician or other Provider of healthcare;
- required to improve a specific health condition of a Member or to preserve his existing state of health; and
- the most clinically appropriate level of healthcare that may be safely provided to the Member.

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

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

❖ **"Mental Health Professional"** means any person qualified and licensed to provide assessments, diagnosis and therapy for mental health conditions or substance use disorders.

❖ **"Mental Illness"** means a pathological state of mind producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning where improvement can reasonably be anticipated with therapy. Mental Illness does not include any Severe Mental Illness as defined in the EOC and otherwise covered under the Severe Mental Illness Covered Services section, or any of the following when they represent the primary need for therapy:

- behavior disorders;
- chronic organic brain syndrome;
- learning disabilities;
- impulse control disorders
- marital or family problems;
- intellectually disabled;
- personality disorder; or
- social, occupational, or religious maladjustment.

- **"Minimum Essential Coverage (MEC)"** means any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance a person must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include:
  - job-based plans;
  - Marketplace plans;
  - Medicare; and
  - Medicaid & CHIP.

- **"Non-Medical 24-Hour Withdrawal Management"** – means an organized residential service, including those defined in American Society of Addiction Medicine (ASAM) criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

- **"Non-Plan Pharmacy"** means a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.

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

- "**Occupational Illness or Injury**" means any Illness or Injury arising out of or in the course of employment for pay or profit.

- "**Open Enrollment Period**" means an annual thirty-one (31) day period of time during which Eligible Employees and their Eligible Family Members may enroll under this Plan without giving HPN evidence of good health.

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

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

- **"Oversize Lenses"** means larger than standard lens blank, to accommodate prescriptions.

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

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

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

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

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

- **"Plan Dentist"** means a Dentist who has an independent contractor agreement with HPN to provide certain Covered Services to Members.

- **"Plan Pharmacy"** means a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.

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

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

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

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

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

- **"Prescription Drug List (PDL)"** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.

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

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

- "**Prior Authorization**" or "**Prior Authorized**" means a system that requires a Provider to get approval from HPN before providing non-emergency healthcare services to a Member for those services to be considered Covered Services. Prior Authorization is not an agreement to pay for a service.

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

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

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

- **"Provider"** means a:
  - Ambulatory Surgical Facility;
  - Dentist;
  - Hospital;
  - Physician;
  - Practitioner;
  - Podiatrist;
  - Skilled Nursing Facility;
  - Urgent Care Facility, or
  - other person or organization licensed by the state where his/the practice is located to provide medical or surgical services, supplies, and accommodations acting within the scope of his/the license.

- **"Reference Product"** means a biological Prescription Drug.

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

- **"Residential Treatment Center"** means a sub-acute facility or acute care facility which delivers twenty-four (24) hours/ seven (7) days a week assessment, diagnostic services and active behavioral health treatment to Members. The level of care and length of stay, in a facility with the appropriate licensure level, is authorized through the HPN Managed Care program.

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

❖ "**Rider**" means a provision added to the Agreement or the EOC to expand benefits or coverage.

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

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

- Bipolar disorder;
- Major depressive disorders;
- Obsessive-compulsive disorder;
- Panic disorder;
- Schizoaffective disorder; and
- Schizophrenia.

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

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

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

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

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

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

❖ **"Small employer"** or small group means as ascribed in 42 U.S.C. § 18024(b)(2).

❖ "**Special Enrollee**" means an Eligible Employee or Eligible Family Member who applies for coverage during a Special Enrollment Period following a Special Enrollment Event.

❖ "**Special Enrollment Event**" means the occurrence of one of the events described below which allows an Eligible Employee and/or Eligible Family Member to enroll under this Plan during a Special Enrollment Period, as follows:

Special Enrollment Event Upon Loss of Coverage Under Another Health Benefit Plan. In the event of a loss of coverage under a Health Benefit Plan that is not COBRA continuation coverage, except where the loss of coverage is due to failure of the Eligible Employee or Eligible Family Member to pay premiums on a timely basis or termination of employment for cause. Loss of coverage under a Health Benefit Plan can be the result of:

- Legal separation, divorce, cessation of Dependent status, death, termination of employment (not for cause) or a reduction in hours of employment;
- Meeting or exceeding a lifetime Health Benefit Plan limit on all benefits under such coverage;
- Termination of employer contributions for the Eligible Employee or Eligible Family Member's coverage;
- Exhaustion of COBRA continuation coverage.

Note: Voluntary cancellation of healthcare coverage is not considered a Special Enrollment Event.

- "**Special Enrollment Period**" means the thirty-one (31)-day period following a Special Enrollment Event during which an Eligible Employee and/or any Eligible Family Members can enroll under this Plan.

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

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

- **"Step Therapy"** is a program for Members who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Member receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Member try a lower cost first-step Covered Drug. If the prescribing Physician has documented with HPN why the Member's condition cannot be stabilized with the first-step Covered Drug, HPN will review a request for Prior Authorization to move the Member to a second-step drug, and so on, until it is determined by HPN that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.

- "**Subrogation**" means HPN's right to bring a lawsuit in the Member's name against any party whom the Member could have sued for reimbursement of covered medical expenses.

- "**Subscriber**" means an employee of the Group who meets the eligibility requirements of this EOC and who has enrolled under this Plan, and for whom premiums have been received and accepted by HPN.

- **"Substance-Related and Addictive Disorder"** as defined in the Diagnostic and Statistical Manual of Mental Disorder (DSM), fifth edition, is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Substance-Related and Addictive Disorder treatment:
  - must be provided as a part of a treatment plan with clearly defined goals that are realistic and measurable. The plan must address significant impairment or deterioration in the Member's occupational or scholastic function, social function, or ability to provide self-care.
  - must be provided by state licensed professionals who are practicing within the scope of this licensure.

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

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

- **"Therapeutic Equivalent"** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.

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

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

- "**Totally Disabled**" means:

- the continuing inability of a Subscriber to substantially perform duties related to his employment or to work for pay, profit or gain at any job for which he is suited by reason of education, training or experience because of Illness or Injury; or
- the inability of a Dependent to engage in his regular and usual activities.

❖ "**Transplant Benefit Period**" means the period beginning with the date the Member receives a written Referral from HPN for care in a Transplant Facility and ending on the first of the following to occur:
a. the date 365 days after the date of the transplant; or
b. the date when the Member is no longer covered under this Plan, whichever is earlier.

❖ "**Transplant Facility**" means a Hospital that has an independent contractor agreement or other contractual relationship with HPN to provide Covered Services related to a Covered Transplant Procedure as defined in this EOC. Non-Plan Hospitals do not have agreements with HPN to provide such services.

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

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

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

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

❖ "**Waiting Period**" means the period of time established by the Group that must pass before coverage for an Eligible Employee or Eligible Family Member can become effective. If an Eligible Employee or Eligible Family Member enrolls as a Special Enrollee, any period before such Special Enrollment is not a Waiting Period.