Nevada Health CO-OP Connected/Conectado (#34996NV023) Evidence of Coverage

This Evidence of Coverage ("EOC") is issued and administered by the Nevada Health CO-OP. This EOC is issued to the Subscriber whose name and Member number appear on his CO-OP identification card. In consideration of enrollment under this EOC and payment of premiums by Subscriber as set forth herein, the CO-OP agrees to provide Covered Services as described in this EOC, including any amendments hereto, subject to its terms and conditions.

This EOC and your attached Attachment A Benefit Schedule tell you about your benefits, rights and duties as a CO-OP Member. They also tell you about the CO-OP's duties to you. If you have any questions regarding any information contained in this EOC, please call the CO-OP Care Department at (702) 823-2667 or (855) 606-2667, the CO-OP's TTY line for the hearing impaired at 711 or go to www.nevadahealthcoop.org. A CO-OP Care Crew Member will be happy to assist 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 the CO-OP are all part of your CO-OP membership package. Please read them carefully and keep them in a safe place. **Words that are capitalized are defined in Section 11. — 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 the CO-OP's Care Management Program and the Prior Authorization process may result in a denial or reduction of benefits.

NOTICE TO MEMBERS

THIS EVIDENCE OF COVERAGE SHOULD BE READ CAREFULLY. IF YOU HAVE QUESTIONS, CALL THE CO-OP CARE DEPARTMENT AT (702) 823-2667 OR (855) 606-2667. IF YOU ARE NOT SATISFIED WITH THIS EVIDENCE OF COVERAGE, YOU MAY RETURN IT, IN PERSON OR BY MAIL, ALONG WITH YOUR IDENTIFICATION CARD TO THE NEVADA HEALTH CO-OP, (702) 823-2667 OR (855) 606-2667, WITHIN 10 DAYS FROM THE DATE IT WAS RECEIVED SO LONG AS COVERED SERVICES UNDER THIS EVIDENCE OF COVERAGE HAVE NOT BEEN UTILIZED DURING THE 10 DAY PERIOD. IMMEDIATELY UPON SUCH DELIVERY OR MAILING, THIS EVIDENCE OF COVERAGE SHALL BE DEEMED VOID AS OF ITS ORIGINAL EFFECTIVE DATE. ANY PREMIUM PAID WILL BE REFUNDED WITHIN 10 DAYS OF THE CO-OP'S RECEIPT OF THE RETURNED EVIDENCE OF COVERAGE.

PARA OBTENER ASISTENCIA EN ESPAÑOL, LLAME AL (702) 823-2667 O (855) 606-2667.

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If you have any questions regarding your health care coverage, please contact the CO-OP Care Department at the following:

Physical Address: **Nevada Health CO-OP**
3900 Meadows Lane, Suite 100
Las Vegas, Nevada 89107

Mailing Address: **Nevada Health CO-OP**
3900 Meadows Lane, Suite 214
Las Vegas, Nevada 89107

Phone: (Monday – Friday from 8:00 a.m. until 6:00 p.m., Pacific Standard Time):

(702) 823-2667 or (855) 606-2667

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 concerning healthcare plans in Nevada.

Hours of operation for the Division:

Monday through Friday from 8 a.m. until 5 p.m., Pacific Standard Time (PST)

The Division is closed during state holidays.

Contact information for the Division:

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

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

The Division also provides a toll-free number for consumers residing outside of the above areas: 1-888-872-3234

PARA OBTENER ASISTENCIA EN ESPAÑOL, LLAME AL (702) 823-2667 o (855) 606-2667 .

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

(a) **Subscriber**. An individual who is (i) a United States citizen or national or lawfully present in the United States, (ii) not incarcerated, other than incarceration pending disposition of charges, and (iii) a resident of the State of Nevada is eligible for guaranteed availability of Coverage.

For catastrophic plans, eligibility is limited to individuals who have not attained the age of 30 before the beginning of the plan year or individuals with appropriate certification of their exemption from the shared responsibility mandate by reason of lack of affordable coverage or hardship.

(b) **Dependent**. To be eligible to enroll as a Dependent, an individual must meet the Dependent eligibility requirements as defined below;

Eligible Dependents, at the time of enrollment and throughout the term of Coverage hereunder include:

- A Subscriber's legal spouse or a legal spouse for whom a court has ordered coverage.
- A Subscriber's Domestic Partner, as defined by Nevada law who is a legal resident in the United States.
- A Subscriber's 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 or Domestic Partner the legal guardian. Children, by birth or adoption, of the Subscriber's Domestic Partner.

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 the CO-OP 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 the CO-OP.

The CO-OP may require proof of continuing incapacity and dependency, but not more often than once a year after the first two (2) years beyond the date when the child reaches the limiting age. The CO-OP's determination of eligibility is final. Evidence of any court order needed to prove eligibility must be given to the CO-OP.

Tax Treatment. By law, unless a Domestic Partner qualifies as a dependent of a Subscriber for purposes of tax-free health coverage under the Internal Revenue Code, the value of coverage provided to the Domestic Partner and any of the Domestic Partner's covered Dependent children for whom the Subscriber is not the legal parent or guardian, less any contributions paid by the Subscriber, are required to be treated as imputed income to the Subscriber for federal income tax purposes.

1.2 Who Is Not Eligible

An Eligible Dependent does not include:

- 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 Effective Dates for Eligibility Determinations

- The initial open enrollment period begins November 15, 2014 and extends through February 15, 2015. From November 15, 2014 (the beginning of open enrollment) until December 15, 2014, the effective date of coverage is January 1, 2015. From December 16, 2014 until February 15, 2015 (the end of open enrollment):
    - if the enrollment occurs between the 1st and 15th of the month, the enrollment is effective the 1st of the next month.
    - if the enrollment occurs between the 16th and end of the month, the enrollment is effective the 1st of the second following month.
- Certain special enrollment situations may result in a mid-plan-year eligibility redetermination that varies from the above open enrollment periods. See the Special Enrollments Period section for more details.

1.4 Verification

To determine your eligibility for enrollment in the Plan as well as eligibility for advance payments of the premium tax credit, cost sharing reductions, Medicaid, CHIP, and other programs, the Marketplace will ask you certain questions to verify your identity. If there is not

enough information on file to generate questions to verify your identity, you may be asked to provide documents establishing your identity. It is your responsibility to provide the required proof as required by the federal government.

1.5 Enrollment

A Subscriber may enroll in this Plan through the Marketplace. When you apply for coverage in the Marketplace, you'll get an eligibility notice that explains what you qualify for

If you enroll in this plan through the Marketplace, you may be eligible for tax credits to help pay for your cost of coverage. Advance Payments of the Premium Tax Credit (APTC) are payments made monthly on your behalf by the federal government directly to a selected insurance carrier thereby decreasing your monthly premium payment. You will need to reconcile these credits when you file your taxes with the IRS at the end of the year. You are generally eligible for the APTC if you:

- Enroll in this plan through the Marketplace;
- Expect to have a household income below 400% of the Federal Poverty Level (FPL) during the plan year;
- Are not eligible for Medicare Part A, Medicaid or other minimum essential coverage; and
- Attest that, for the plan year:
  - You will file an income tax return;
  - You will file a joint tax return (only applies if you are married);
  - No other taxpayer will be able to claim you as a tax dependent; and
  - You will claim a personal exemption deduction on your tax return for the members of your family, including you and your spouse.

1. **Open Enrollment**. The Marketplace provides annual open enrollment periods during which you may enroll in the Plan or change to a different QHP, if eligible. You are only permitted to change QHPs during the annual open enrollment period, or a special enrollment period for which you have been found eligible.

2. **Special Enrollment**. Outside of the annual open enrollment periods, A Subscriber may encounter a qualifying life event that makes the Subscriber or his or her Dependents newly eligible for another plan, ineligible for him or her current plan, or entitles you to add or delete from coverage a member of his or her household. These qualifying life events trigger a special enrollment period, in which a Member is permitted to change plan selection. The Member has sixty (60) days from the date of a triggering event to complete a plan selection. "Plan selection" includes selecting a plan and providing the required documentation and payment, if applicable. Unless otherwise indicated below, Coverage is effective:

- For a plan selection completed on the 1st through the 15th of a month, the following month; and
- For a plan selection completed on the 16th through the last day of a month, the second following month.

There are other complicated cases that may allow a Subscriber to qualify for a special enrollment period. Examples include: exceptional circumstances, such as facing an unexpected hospitalization or a natural disaster; misinformation or misrepresentation by a non-Marketplace enrollment assister (like an insurance company, navigator, certified application counselor, or agent or broker) that resulted in you not getting enrolled in a plan, being enrolled in the wrong plan or not getting the APTC or CSR that you were eligible for; a technical enrollment error between the Marketplace and the CO-OP or another issuer; system errors related to immigration status; plan data display errors on the Marketplace; invalid Medicaid/Marketplace transfers; or application error messages. If you think you qualify for a special enrollment period, contact the Marketplace Call Center at 1-800-318-2596.

1.6 Special Eligibility and Enrollment Rule for Native Americans

If you are an American Indian or an Alaska Native you may have new health insurance benefits and protections in the Marketplace. Some benefits are available to members of federally recognized tribes. Others are available to people of Indian descent or who are otherwise eligible for services from the Indian Health Service, a tribal program, or an urban Indian health program.

If you are a verified American Indian or Alaskan Native, you are permitted to change your QHP selection a maximum of once every thirty (30) days. Applicants may need to provide documentation of U. S. citizenship. For monthly special enrollment periods and no out-of-pocket costs in the Marketplace, members of federally recognized tribes who are eligible to enroll in a health plan offered through the Marketplace will need to provide documentation showing membership in a federally recognized tribe.

Please note that if you change your plan selection, all of your plan accumulators such as deductibles and out of pocket maximums will be reset under the new plan.

Additionally, if you are an American Indian or Alaskan Native, you may be eligible for no cost sharing (100% AV) plan; you will not pay deductibles, Coinsurance, Copayments or out of pocket maximums. To qualify for these special cost sharing reductions:

- You must be eligible for Advance Payments of the Premium Tax Credit (APTC);
- Your household income must be no more than 300 percent of the Federal Poverty Level (FPL); and
- You must be enrolled in a plan in the individual market through the Marketplace.

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

1.7 Changes In Eligibility Status & Redetermination During a Plan Year

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

- reaching the limiting age.
- ceasing to satisfy the mental or physical handicap requirements.
- death.
- divorce.
- transfer of residence outside Nevada.
- any other event which affects a Dependent's eligibility.

Coverage for ineligible Members will terminate in accordance with the termination provisions described in this EOC.

In addition, you must report to the Marketplace certain life changes that occur during the plan year that may affect your eligibility. This information may change the coverage and savings that you are eligible to receive. You must report a change if you:

- get married or divorced;
- have a child, adopt a child, or place a child for adoption;
- have a change in income;
- get health coverage through a job or a program like Medicare or Medicaid;
- change your place of residence;
- have a change in disability status;
- gain or lose a Dependent;
- become pregnant; or
- experience other changes that may affect your income and household size, such as a change in tax filing status; change of citizenship or immigration status; incarceration

or release from incarceration; change in status as an American Indian/Alaska Native or tribal status; correction to name, date of birth, or Social Security number.

You should report these changes to the Marketplace as soon as possible. If these changes qualify you for a special enrollment period to change plans, in most cases you have 60 days from the life event to enroll in new coverage. If the changes qualify you for more or less savings, it's important to make adjustments as soon as possible.

Important: Do not report these changes by mail. You can report these changes either online by logging into your Marketplace account or by phone. Contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) or visit https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/.

After you report changes to the Marketplace, you'll get a new eligibility notice that will explain:

- whether you qualify for a special enrollment period that allows you to change plans
- whether you're eligible for lower costs based on your new income, household size, or other changed information. You may become eligible for the first time, for a different amount of savings, or for coverage through Medicaid or the Children's Health Insurance Program (CHIP). You also could become ineligible for savings--if your income has gone up, for example.

If you're eligible for a special enrollment period, you will be able to shop for a different plan in the Marketplace. You usually have up to 60 days from the date of the qualifying event to enroll in a new plan.

If you have a special enrollment period, you can change plans either online by logging into your Marketplace account or by phone. Contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

If you're not eligible for a special enrollment period but the tax credit you qualify for has changed, then you can not change plans, but you can choose to adjust the amount of the APTC to apply to your monthly premiums.

If you take the APTC, it's important to report any changes in your income or family size to the Marketplace throughout the year. Reporting these changes, will help you get the proper type and amount of financial assistance so you can avoid getting too much or too little in advance.

Please note that the amount you receive in APTC will be reconciled when you file your taxes and you could incur a large liability if you do not report income changes in a timely manner. The government makes advance payments of the credit based on an estimate of the credit that you will claim on your tax return when you file in 2015. If you report changes in your income or family size to the Marketplace when they happen in 2014, the advance payments will more closely match the credit amount on your 2014 federal tax return. This will help you avoid getting a smaller refund than you expected or even owing money that you did not expect to owe

1.8 Effective Date of Coverage

Before coverage can become effective, A Subscriber must provide all required documentation and payment, if applicable.

1. Unless otherwise indicated below, coverage is effective:

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

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

2. For a Subscriber's new spouse or Domestic Partner, Coverage shall commence on the first day of the month following the marriage or Domestic Partnership certification provided evidence of the marriage or Domestic Partnership and any additional payment is timely submitted.

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

In addition, Subscriber must give the CO-OP a copy of the certified birth certificate for coverage to continue after thirty-one (31) days for newborn children.

4. Subscriber's newborn 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. In either case, coverage continues beyond the thirty-one (31) day period only if the Subscriber enrolls the child as a Dependent and pays the required premium or fees within sixty (60) days after the placement of the child in the Subscriber's home.

In addition, Subscriber must give the CO-OP a copy of the decree of adoption, or certificate of Placement for Adoption for coverage to continue after thirty-one (31) days for adopted children.

However, in the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.

5. 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 provided.

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 is terminated pursuant to Sections 2.1 and 2.2 below, the coverage of his Dependents will also be terminated.

2.1 Termination by the CO-OP

The CO-OP may terminate coverage under this Plan at the times shown for any one or more of the following reasons:

- If premium payments for the Subscriber and enrolled Dependents are not received by the CO-OP within the Grace Period defined in this EOC, Coverage shall automatically terminate without further notice to Subscriber. A Grace Period of ten (10) days will be granted for the payment of each premium due after the first premium, during which the EOC will continue in force. The date of termination will be the last day of the month for which premium payments have been received and accepted by the CO-OP.
  - For any Subscriber or enrolled Dependents who are receiving APTCs, a Grace Period of three (3) consecutive months will be granted for the payment of each premium due after the first premium and the CO-OP will provide the Subscriber with notice of the payment delinquency fifteen (15) days after the date such premium is due. The date of termination will be the last day of the first month of the Grace Period.

  The CO-OP will pay appropriate claims for the first month of the Grace Period and may pend claims in second and third months of the Grace Period. Subscriber shall not be permitted to unilaterally reinstate Coverage through the submission of premium after the date on which this EOC was terminated pursuant to this provision. Premium payments received by the CO-OP following expiration of the Grace Period shall be returned to Subscriber and Subscriber shall not be entitled to further Coverage hereunder.
- If a Member performs an act or practice that constitutes fraud, or makes any intentional misrepresentation of material fact, as prohibited by the terms of coverage, the CO-OP has the right to rescind coverage and declare coverage under the Plan null and void as of the date of the occurrence of the fraud or intentional misrepresentation of material fact, or, if later, the original Effective Date of Coverage, and refund any applicable premium after deducting any costs incurred by the CO-OP as a result of the fraud or intentional misrepresentation. Acts of fraud or misrepresentation include the Member allowing his or any other Member's CO-OP ID Card to be used by any other person, or using another person's CO-OP ID Card, and knowingly furnishing incorrect or incomplete information to the CO-OP in order to obtain benefits for the Subscriber, enrolled Dependents, or a non-enrolled individual. The Member will be liable to the CO-OP for all costs incurred as a result of the fraud, misrepresentation or misuse of the CO-OP ID Card. 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.

- If a Member is no longer eligible for coverage through the Plan for any reason, including, without limitation, the Member's loss of residency in the State of Nevada, the date of termination will be the last day of the month following the month in which the notice is sent by the Marketplace or the CO-OP unless the Member requests an earlier termination effective date.
- If the CO-OP discontinues coverage for this particular Health Plan in the State of Nevada, Coverage under this Evidence of Coverage will terminate. A 180 day written notice of termination will be provided by the CO-OP and mailed to the Subscriber's address of record. Subscriber, and his enrolled Dependents, will have the option of purchasing other health insurance offered by the CO-OP in the individual market.
- If the CO-OP ceases to offer coverage in the individual market in the State of Nevada, Coverage under this Evidence of Coverage will terminate. A 180 day written notice of termination will be provided by the CO-OP and mailed to the Subscriber's address of record.
- If a Subscriber changes from this Plan to another through open/special enrollment, the last day of coverage in the Plan will be the day before the effective date of coverage in his or her new plan.
- If a Member commits acts of physical or verbal abuse that pose a threat to our staff.

2.2 Termination by the Subscriber

Subscriber has the right to terminate his coverage under this Plan. You can cancel coverage you bought through the Marketplace online by logging into your account.

Important: If you cancel coverage without replacing it, you may have to pay a fee for the months you're not covered. You'll also have to pay all of your medical expenses.

Such termination is effective on the termination date specified by the Subscriber, if the Subscriber provides fourteen (14) days' prior written notice or fourteen (14) day after the termination is requested by the Subscriber if the Subscriber does not provide reasonable notice. If the Subscriber requests an earlier termination date, the Plan may agree to terminate coverage in fewer than fourteen (14) days after the request.

If the Subscriber changes to another qualified health plan during an annual open enrollment or special enrollment period, the last day of coverage is the day before the new qualified health plan coverage begins. If the Subscriber is newly eligible for Medicaid or CHIP, the last day of coverage is the day before such Medicaid or CHIP coverage begins.

Cancellation of Subscriber's membership will also terminate Coverage for Subscriber's enrolled Dependents.

There are no pro-rated refunds given for terminating coverage in the middle of the month, and all coverage begins at the beginning of the month according to the policies and guidelines outlined in this Evidence of Coverage. All premiums are paid before the month of coverage, and once paid, are non-refundable.

2.3 Reinstatement

If any renewal premium is not paid within the time granted the Subscriber for payment, a subsequent acceptance of premium by the CO-OP or by any agent duly authorized by the CO-OP to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the EOC; provided, however, that if the CO-OP or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the EOC will be reinstated upon approval of such application by the CO-OP or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless the CO-OP has previously notified the Subscriber in writing of its disapproval of such application. The reinstated EOC shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the CO-OP and Subscriber shall have the same rights thereunder as they had under the EOC immediately before the due date of the defaulted premium, subject to any provisions endorsed herein or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

2.4 Rescission

As set forth in Section 2.1 above, if a Member performs an act or practice that constitutes fraud or makes any intentional material misrepresentation of fact or material omission to the CO-OP, it shall be cause for termination and rescission of the Coverage of the Member about whom the material misrepresentation of fact or material omission pertains. The CO-OP will timely notify Subscriber regarding such rescission and the CO-OP will refund any premium amounts paid by Subscriber minus any claims paid to providers on behalf of Subscriber, or Subscriber's enrolled Dependents. The CO-OP will seek reimbursement from the Subscriber for any amounts paid that exceed the premiums received. The CO-OP will not provide Coverage following the date of rescission and will not be responsible for any charges incurred on or after the date of rescission. Misrepresentations of fact include, but are not limited to the following:

1. any failure to disclose to the CO-OP the Member's tobacco use prior to the effective date of Coverage hereunder;

2. any misrepresentation of a Member's age; and

3. any material false statements or omissions in any part of the Enrollment Application.

The individual whose signature appears on the Enrollment Application is responsible for the accuracy and completeness of the Enrollment Application, including any information regarding or known by any other person who is listed on the Enrollment Application. Coverage for the adult primary Subscriber shall be terminated if the adult primary subscriber has committed an act of fraud or has made an intentional misrepresentation of material fact by submitting an application that contains material misstatement or commission. If Coverage is rescinded or terminated under this provision, Dependents listed on the Enrollment Application

for whom there was no misrepresentation of fact, except as stated above, will remain in force on the Evidence of Coverage.

2.5 Effect of Termination

No benefits will be paid under this Plan by the CO-OP 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.

SECTION 3. CARE MANAGEMENT PROGRAM

This section tells you about the CO-OP's Care Management Program.

3.1 Care Management Program

The CO-OP's Care Management 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. The CO-OP's Care Management Program helps direct care to the most appropriate setting to provide healthcare in a cost-effective manner.

3.2 Care Management Program Requirements

The CO-OP's Care Management Program requires the Member, Plan Providers and the CO-OP to work together.

- All Plan Providers have agreed to participate in the CO-OP's Care Management Program. Plan Providers have agreed to accept the CO-OP's Reimbursement Schedule amount as payment in full for Covered Services, less the Member's payment of any applicable Copayment, Deductible or Coinsurance amount, whereas Non-Plan Providers have not. In no event will the CO-OP pay more than the maximum payment allowance established in the CO-OP 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 the CO-OP's Care Management Program.

When required, compliance by the Member with the CO-OP's Care Management Program is mandatory. Failure to comply with the rules of the CO-OP's Care Management Program means the Member will be responsible for costs of services received.

3.3 Care Management Program Process

The Care Management Program's medical professionals may 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, the CO-OP will complete the Prior Authorization form 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 or not any care should be received is between the Member and the Provider. If the CO-OP 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 CO-OP's Advocacy Department (see the Appeals Procedures Section herein).

3.4 Services Requiring Prior Authorization

Certain Covered Services require Prior Authorization and review through the CO-OP's Care Management Program. The Attachment A Benefit Schedule shows which Covered Services may require Prior Authorization. Such list is subject to change and approval of some Covered Services may require participation in the CO-OP's medical management programs.

You do not need Prior Authorization in order to obtain access to OB/GYN care from a Provider who specializes in obstetrics or gynecology. The Provider, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a preapproved treatment plan or procedures for making referrals. For a list of current Plan Providers call (702) 823-2667 or (855) 606-2667 or view the list online at www.nevadahealthcoop.org.

For medical care that requires Prior Authorization, you may notify us as follows:

- Have the Physician call us at (855) 897-0316;
- Call us directly at (702) 823-2667 or (855) 606-2667;
- Have an authorized representative call the CO-OP on your behalf, if it is not possible for you or your Provider to call the CO-OP.

3.5 Emergency Admission Notification

The Member must report all emergency admissions to the CO-OP Care Department within 24 hours of admission or as soon as reasonably possible to authorize continued care at (702) 823-2667 or (855) 606-2667.

Members requiring Emergency Services will not be required to obtain Prior Authorization from the CO-OP prior to receiving an initial medical screening examination and any immediate treatments or services necessary to stabilize a condition. This applies to both Plan Providers and non-Plan Providers. **If you are faced with a medical emergency, call 911 or go to the nearest emergency room.**

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.

3.6 Hospitalist Program

Inpatient Care from Hospitalist Program physician. If a Member is admitted as an inpatient at a Hospital at which a Hospitalist Program exists, the Member is subject to the Hospitalist Program.

(a) Inpatient care by the Hospitalist Program physicians is required for all Members. This is inpatient care by primary care physicians only. Primary care physicians are general practice, family practice and internal medicine Physicians. The Hospitalist Program does not include Physician care by specialists such as cardiologists, dermatologists, oncologists or anesthesiologists. For purposes of the Hospitalist Program only, OB/GYN and pediatric Physicians are considered specialists, not primary care physicians.

For inpatient Physician primary care under the Hospitalist Program, the Plan will pay the full Allowable Expense including any copays, Coinsurance and Deductibles. The Member will not have any out of pocket expenses for covered services by Hospitalist Program physicians. Care by specialists will continue to be covered and paid as normal under the Plan's Rules.

(b) If the Member refuses care from the Hospitalist Program physician and instead accepts inpatient Hospital care from his own primary care physician (not including OB/GYN and pediatric Physicians) or any other non-specialist Hospital based Physician outside of the Hospitalist Program, the Plan will pay nothing for such care and the Member will be solely responsible for all amounts billed by such primary care physician.

(c) A Member who has been admitted and is receiving care from a Hospitalist Program physician also may accept care from his pre-established primary care physician who has been actively involved in the Member's ongoing primary care. However, his pre-established primary care physician providing care to an admitted Member will be reimbursed by the Plan for a consultation only and will not be the manager of the Member's inpatient care.

3.7 Independent Medical Review; Appeals Rights

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

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

If the Member disagrees with the findings of the review, he must submit an appeal for binding arbitration to the CO-OP within thirty (30) days after he receives the report. Please refer to the Appeals Procedures Section in this EOC for more information.

3.8 Appeals Rights

All decisions of the CO-OP's Care Management Program may be appealed by the Member through the Appeals Procedures as described in Section 10. If an imminent and serious threat to the health of the Member exists, the appeal will be directed to the CO-OP's Medical Director.

SECTION 4. OBTAINING COVERED SERVICES

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

4.1 TeleHealth Services

This Plan encourages Patients and their Physicians to connect primarily through the use of TeleHealth technology. The TeleHealth PCP will be available to provide an initial evaluation by phone or other TeleHealth technologies. A Member can then go to an in-person office visit or seek other Covered Services as appropriate.

A Member is responsible for maintaining an adequate telecommunications system that permits real-time interactive communication between the Member and the TeleHealth PCP.

It is important to establish your TeleHealth PCP for your convenience.

4.2 Availability of Covered Services

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

(a) Specifically authorized through the CO-OP's Care Management Program;

(b) Received through a Plan Provider; and

(c) 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 the CO-OP's Care Management Program.

Eligible American Indians, as determined by the Marketplace, are exempt from cost-sharing requirements when Covered Services are rendered by an Indian Health Services (IHS), Indian Tribe, Tribal Organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these Providers.

4.2 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 the CO-OP.

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 the CO-OP; or
- If the medical condition is pregnancy, the 45th day after the date of delivery or if the pregnancy does not end in delivery the date of the end of the pregnancy.

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

Address:

Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, Nevada 89107

Phone:

(702) 823-2667
(855) 606-2667

4.3 Incentive Program

The CO-OP may develop a program designed to help Members understand their health status and support them in making positive lifestyle and behavior changes. Participation in the program would require the completion of specified activities. If the CO-OP develops an incentive program, participation in and/or completion of the identified activities will be voluntary and will not be required for participation in or coverage by this Plan. If and when such program is developed, you will be provided with the details in a separate communication.

Incentives may include reduced Coinsurance or Copayment levels or other financial incentives. Incentives would be based upon completion of required health actions and not the

outcome of those actions. If any Member was required to complete personal health actions in order to receive an incentive but was unable to do so, that Member and/or the Member's Physician would be allowed to request a reasonable alternative or waiver by contacting the CO-OP Care Department at (702) 823-2667 or (855) 606-2667.

The CO-OP reserves the right to design and offer an incentive program for its Members. In all cases, the decision to participate in the program and any related treatment decisions will reside with the Member and his or her Physician.

SECTION 5. COVERED SERVICES

This section tells you what services are covered under this Plan. Only services and supplies that meet the CO-OP's definition of Medically Necessary will be considered to be Covered Services. The Attachment A Benefit Schedule shows applicable Copayments, benefit limitations and Prior Authorization requirements for Covered Services.

5.1 Healthcare Facility Services

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

Accommodations:

- Semiprivate (or multi-bed 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 applied 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.

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

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

5.2 Medical – Physician Services

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

Covered 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
- Acupuncture.

5.3 Specialty Services and Consultations

Covered Services include medical services rendered by a Specialist or other duly licensed Provider whose opinion or advice is requested by the Member's PCP or the CO-OP's Care Management Program professionals for further evaluation of an Illness or Injury on an Inpatient or outpatient basis, and including a TeleHealth consultation.

There will be no charge to a Member when seeking a second opinion for surgical or specialty services who has received Prior Authorization from the CO-OP's Care Management Program.

5.4 Preventive Services

Covered Preventive Services will be paid at 100% of Allowable Expenses, without application of any Copayment, and/or Calendar Year Deductible and Coinsurance when such services are provided by a Plan Provider. In the absence of specific guidance in a federal Preventive Service guideline or recommendation, the Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended Preventive Service.

Covered Services include the following Preventive Services in accordance with the recommended schedule outlined in the CO-OP Preventive Guidelines included in your member kit or you may access the most current version of these guidelines at any time by visiting the CO-OP's web site at www.nevadahealthcoop.org.

- 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") as set forth at the following link;

  http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
- Immunizations 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.

5.5 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.

5.6 Oral Physician Surgical Services

Although dental services are not Covered Services, 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 is necessary in order to perform radiation therapy.
- Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Injury (not to include injuries caused by chewing) when the treatment starts within the first ten (10) days after the Injury and ends within sixty (60) days. Examples of Covered Services, in such instances, include:
    - Root canal therapy, post and build up.
    - Temporary crowns.
    - Temporary partial bridges.
    - Temporary and permanent fillings.
    - Pulpotomy.
    - Extraction's of broken teeth.
    - Incision and drainage.
    - Tooth stabilization through splinting.

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

5.7 Organ and Tissue Transplant Surgical Services

All Covered Transplant Procedures are subject to the provisions of the CO-OP's Care Management Program and all other terms and provisions of the Plan, including the following:

1. The CO-OP's Care Management Program's professionals will determine if the Member satisfies the CO-OP's Medically Necessary criteria before receiving benefits for transplant services.

2. The CO-OP's Care Management Program's professionals will provide a written Referral for care to a Transplant Facility.

3. If, after Referral, either the CO-OP's Care Management Program's professionals 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 procurement.
- Organ and tissue retrieval which includes removing and preserving the donated part.
- Rental of wheel chairs, Hospital-type beds and mechanical equipment required to treat respiratory impairment.
- Ambulance services.
- Medication, x-rays and other diagnostic services.
- Laboratory tests.
- Oxygen.
- Surgical dressings and supplies.
- Immunosuppressive drugs.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Reasonable and necessary costs for 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.

The CO-OP makes no representation or warranty as to the medical competence or ability of any Transplant Facility or its respective staff or Physicians. The CO-OP 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.

The CO-OP 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 Allowable Expenses incurred during the Transplant Benefit Period.

5.8 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.

5.9 Emergency 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 Allowable Expenses for Non-Plan Provider Emergency Services as defined under "CO-OP Reimbursement Schedule". Members are responsible for any Non-Plan Provider Emergency Service charges that exceed payments made by the CO-OP.

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

(a) **Within the CO-OP's Service Area**.

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 Allowable Expenses for care required before the Member can safely receive services from a PCP.

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

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

The Member should notify the CO-OP 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 the CO-OP's Service Area.

1. **Payment**. Benefits are limited to the Allowable Expenses for such Covered Services.

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 the CO-OP's Service Area.

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

5.10 Ambulance Services

Covered Services include Ambulance Services to the nearest appropriate Hospital. The CO-OP will make direct payment to a Provider of Ambulance Services if the Provider does not receive payment from any other source.

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

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

- Professional services of a registered nurse, licensed practical nurse or a licensed vocational nurse on an intermittent basis.
- Physical therapy, speech therapy and occupational therapy by a licensed therapist.
- Medical and surgical supplies that are customarily furnished by the Home Healthcare agency or program for its patients.
- Prescribed drugs furnished and charged for by the Home Healthcare agency or program, including home infusion therapy.
- Health aide services furnished to Member only when receiving nursing services or therapy.
- Prior authorized medical social services and nutritional consultations by a certified registered dietitian may be covered.

5.12 Short-Term Habilitative and Rehabilitation Services – Inpatient and Outpatient

Short-Term Habilitative and Rehabilitation therapy Covered Services include:

- Speech therapy.
- Occupational therapy.
- Physical therapy on an Inpatient or outpatient basis. Inpatient physical therapy requires Prior Authorization.

Benefits for habilitation and rehabilitation therapy are limited to services given for acute or recently acquired conditions or congenital defects that, in the judgment of the Member's PCP and the CO-OP's Care Management 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 mental retardation or delayed development.

5.13 Laboratory Services

Covered Services include prescribed diagnostic clinical and anatomic pathological laboratory services and materials.

5.14 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, but only when no charges are made for the same services and/or supplies by a Hospital, Skilled Nursing Facility or an Ambulatory Surgery Center.

5.15 Other Diagnostic and Therapeutic Services

Diagnostic and Therapeutic Covered Services 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. The financial limits applicable to oral chemotherapy will be no less favorable than the financial limits applicable to chemotherapy administered by injection or intravenously;
- 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 the CO-OP, including but not limited to, non-cancer related intravenous injection therapy; and
- Positron Emission Tomography (PET) Scans.

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

5.16 Prescription Drugs

The Plan covers generic, formulary, non-formulary, specialty and Preventive Care Drugs at Contracting Pharmacies. Different Copayments, calendar year deductibles and Coinsurance may apply to generic, formulary, nonformulary drug benefits. A percentage of specialty Drugs are covered after the Calendar Year Deductible is satisfied. Specialty Drugs, including specialty medications delivered in a Provider's office, are subject to Prior Authorization. Members may be required to obtain certain Specialty Drugs through a CO-OP contracted specialty pharmacy. Please refer to your Attachment A Benefit Schedule and contact the CO-OP Care Department for additional information.

For maintenance Drugs that may be taken for longer than 30 days, Members may obtain up to a 90-day supply of covered medications mailed directly to their home. Different Copayments apply to most mail-order drug benefits. Please refer to your Attachment A Benefit Schedule.

Preventive Care Drugs are those Drugs which are required to be covered by the Plan at 100% of Allowable Expenses in accordance with the Preventive Guidelines set forth in Section 5.4, Preventive Services. The list of Preventive Care Drugs will be amended from time to time to reflect updated federal guidance and recommendations. To obtain a list of Preventive Care Drugs, please contact the CO-OP Care Department at (702) 823-2667 or (855) 606-2667.

Step therapy programs target highly utilized drug categories that contain multiple drugs with a high degree of interchangeability and generic availability. Step therapy programs promotes safe and effective drug therapy while maximizing on cost-savings associated with generic or preferred brand utilization.

Current categories include:

- Androgens - Testosterone replacement
- Angiotensin II Receptor Blockers (ARB’s) - High Blood Pressure
- Atypical Antipsychotics - Mental health conditions
- Bisphosphonates - Osteoporosis
- GLP Inhibitors - Diabetes

- Insulin - Diabetes
- Insulin, Basal - Diabetes
- Intranasal Steroids - Nasal Allergy
- Proton Pump Inhibitors - Ulcers
- Triptans – Migraines

The Prior Authorization (PA) Program is designed to manage the utilization of specialty drugs that are relatively expensive, have significant potential for misuse or abuse, or require close monitoring because of potentially serious side effects. Examples of current categories include oral oncology, biologic agents for rheumatoid arthritis and multiple sclerosis and growth hormone products. For additional information on Drugs requiring Prior Authorization, please contact the CO-OP Care Department.

Key features of the PA focus are:

- Ensuring services delivered are clinically appropriate and cost-effective
- Eliminating barriers to obtain unusual, high-cost, or high-risk drugs when medically appropriate
- Encouraging open care-option dialogues among members, their pharmacists, and their prescribers

Excluded Drugs are Cosmetic (hair loss products, etc.) and anorexiants (weight loss products). Information regarding the Plan's formulary may be obtained by contacting the CO-OP Care Department at (702) 823-2667 or (855) 606-2667.

5.17 Prosthetic and Orthotic Devices

Covered Services include the following devices when received in connection with an Illness or Illness:

- 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 Prosthetic or Orthotic Device required by wear or by change in the patient's condition when ordered by a Provider.
- Diabetic orthotic shoes, one pair per year.

5.18 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 the CO-OP's Care Management 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.

The CO-OP will not be responsible for the following:

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

5.19 Mental Health Services, Severe Mental Illness and Substance Use Disorder Services

All benefits for Mental Health, Severe Mental Illness and Substance Use Disorder Services are subject to the CO-OP Cares Assistance Program through the CO-OP's Behavioral Health/Substance Use Disorder Provider and shown in the Attachment A Benefit Schedule.

Mental Health Services. When authorized by the CO-OP's Behavioral Health/Substance Use Disorder Provider, Covered Services include evaluation, crisis intervention or psychotherapy only.

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

Severe Mental Illness Services. When authorized by the CO-OP's Behavioral Health/Substance Use Disorder Provider, Covered Services include Inpatient and outpatient treatment for Severe Mental Illness as defined in this EOC. Benefits for the treatment of Severe Mental Illness are subject to the benefit levels shown in the Attachment A Benefit Schedule.

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

Substance Use Disorder Services. Substance Use Disorder services include the following:

- **Inpatient**: when determined by the CO-OP's Behavioral Health/Substance Use Disorder Provider to be necessary, or when outpatient treatment is not feasible, services for diagnosis and medical treatment for alcoholism and abuse of drugs.
- **Outpatient**: services for the diagnosis, medical treatment and rehabilitation, including individual, group, and family counseling, and outpatient detoxification services for recovery from the effects of alcoholism and abuse of drugs.
- **Detoxification**: treatment for withdrawal from the physiological effects of alcohol and drug abuse. Inpatient detoxification is considered appropriate treatment only for life-threatening withdrawal syndromes associated with drug and alcohol dependence.

NOTE: All Inpatient and non-routine outpatient non-emergency Mental Health, Severe Mental Illness or Substance Use Disorder services require Prior Authorization by the CO-OP's Behavioral Health/Substance Use Disorder Provider. Members must contact the CO-OP at 702-823-2667 or 855-606-2667 for assistance in obtaining Prior Authorization for Covered Services. The CO-OP's Behavioral Health/ Substance Use Disorder Provider will assist in scheduling an appointment or will make a referral to the appropriate Provider based on the service requested and the associated level of acuity. If the Member is unable to contact the CO-OP due to an emergency admission the Member must contact the CO-OP as soon as reasonably possible following the emergency admission to obtain Prior Authorization of any needed follow up care.

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

5.20 Mastectomy Reconstructive Surgical Services

Benefits are available for Subscribers and their enrolled Dependents for Mastectomy Reconstructive Surgery. Mastectomy Reconstructive Surgery is the surgical procedure

performed following a mastectomy on one or both breasts to re-established symmetry between the two breasts. Such surgery includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy.

The following services received in connection with Mastectomy Reconstructive Surgical Services are Covered Services subject to the terms and conditions of this EOC:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending Physician and the patient.

The first three (3) years after mastectomy:

Benefits for reconstructive surgery, including complications relating to the reconstructive surgery, performed while the patient is covered under this Plan, and within the three (3) years immediately following a mastectomy that was covered under this Plan, will be paid at the same level as would have been provided at the time of the mastectomy.

More than three (3) years after mastectomy:

Benefits for reconstructive surgery performed more than three (3) years following a mastectomy that was covered under this Plan (if the patient is still covered by the CO-OP under this Plan) will be paid subject to all of the terms, conditions and exclusions contained in the EOC at the time of the reconstructive surgery.

No benefits will be paid for reconstructive surgery performed, or any complications relating to the reconstructive surgery, more than three (3) years following a mastectomy that was covered under this Plan if the patient is no longer covered by the CO-OP under this Plan.

5.21 Special Food Product / Enteral Formulas

Covered Services include enteral formulas and special food product when prescribed by a Physician and authorized by the CO-OP's Care Management Program for treatment of an inherited metabolic disease.

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

5.22 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.

5.23 Dental Anesthesia Services

Covered Services include general anesthesia, when rendered in a Hospital, outpatient surgical facility, or other duly licensed facility for an enrolled Dependent child up to age 16, when such child, in the treating dentist's opinion and as Prior Authorized by the Plan, satisfies one or more of the following criteria:

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

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

5.24 Gastric Restrictive Surgical Services

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

- Have a body mass index (BMI) of greater than 40kg/m2; or
- Have a BMI greater than 35kg/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 three (3) months with documented failure of weight loss. Significant clinical evidence that weight is affecting overall health and is a threat to life will also be required.

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

5.25 Genetic Disease Testing Services

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

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

5.26 Clinical Trial or Study

Covered Services include coverage for 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;
- The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or Phase II, Phase III, or Phase IV clinical trial or study for chronic fatigue syndrome;
- The clinical trial or study is approved by:

    1. An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b) or other federal agency;

    2. A cooperative group;

3. The Food and Drug Administration (FDA) as an application for a new investigational drug;

4. The U.S. Department of Veterans Affairs; or

5. The U.S. Department of Defense.

- 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 or not 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;
- Routine health care services that would otherwise be covered for the Member;
- 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, and, for a Phase I study, when such services are not directly related to such study.

Benefit coverage for medical treatment received during a clinical trial or study does not include:

- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;

- Health care services that are specifically excluded from coverage under this Plan, regardless of whether such services are provided under the clinical trial or study;
- Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study;
- Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant 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 insured; and
- Any costs for the management of research relating to 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. Since there are no allowables for clinical trials, the CO-OP medical team will determine allowable rates based on the closest reasonable allowable for similar services. However, the coverage described above is not required to be covered if any such medical treatment is provided by the sponsor of the clinical trial or study free of charge to the Member.

Covered Services available for the clinical trial or study will be provided by a Plan Provider. If the Member must utilize a Non-Plan Provider, then the Non-Plan Provider shall be reimbursed at the same rate authorized to Plan Providers of similar services and the Non-Plan Provider shall accept the CO-OP's rate of reimbursement as payment in full.

The CO-OP 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.

In addition, if a Member participates in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition, the CO-OP will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial and will not discriminate against the Member on the basis of the individual's participation in the trial. An "approved clinical trial" means a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

A Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; if either: (1) the referring health care professional is a Plan Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Member provides medical

and scientific information establishing that the individual's participation in such trial would be appropriate.

For questions about the coverage for clinical trials provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact the Nevada Division of Insurance at 1-888-872-3234, or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789.

5.27 Medical Supplies

Medical Supplies are routine supplies that are prescribed by a physician and customarily used during the course of treatment for an Illness or Injury. Medical Supplies include, but are not limited to the following:

- Catheter and catheter supplies – Foley catheters, drainage bags, irrigation trays;
- Colostomy bags (and other ostomy supplies);
- Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lambs wool pads, sterile solutions, ointments, sterile applicators, sterile gloves;
- Elastic stockings;
- Enemas and douches;
- InfIV supplies;
- Sheets and bags;
- Splints and slings;
- Surgical face masks;
- Syringes and needles; and
- One Wig because of hair loss due to chemotherapy or radiation treatment for cancer.

5.28 Post-Cataract Surgical Services

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

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

5.29 Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for one purchase of a prescribed, CO-OP formulary approved hearing aid device from a Plan Preferred Provider. For these purposes a "Plan Preferred Provider" means a preferred hearing aid supplier as designated by the CO-OP. For a list of Plan Preferred Providers, contact the CO-OP.

Benefits are provided for the purchase of the hearing aid and for charges for associated fitting and testing. Repairs or replacements are covered once every three (3) years.

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 CO-OP EOC, only for Members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

5.30 Infertility Services

Covered Services include limited diagnostic and therapeutic infertility services determined to be Medically Necessary that are performed by a Plan Preferred Provider and Prior Authorized by the CO-OP's Care Management Program. For these purposes a "Plan Preferred Provider" means a preferred OB/GYN Provider as designated by the CO-OP. Not all Plan Providers who perform OB/GYN services qualify as Plan Preferred Providers. For a list of Plan Preferred Providers, contact the CO-OP.

Covered Services do not include those services specifically excluded herein, but do include limited:

- Laboratory studies;
- Diagnostic procedures; and
- Up to six (6) ovulation cycles per Member per lifetime.

5.31 Autism Spectrum Disorder

Covered Services include Medically Necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders for Members under the age of 18 or, if enrolled in high school, until such Member reaches the age of 22. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst (including an Assistant Behavior Analyst and/or Certified Autism Behavior Interventionist) and are subject to the CO-OP Cares Assistance Program. With the exception of the specific limitation on benefits for Applied Behavior Analysis ("ABA") as outlined in Attachment A Benefit Schedule, benefits for all Covered Services for the treatment of Autism

Spectrum Disorders are payable to the same extent as other Covered Services and Covered Drugs under the Plan.

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

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

5.32 Pediatric Vision

The Plan covers one routine pediatric eye exam per year, including low vision evaluations, as well as one pair of eye glasses, one optional lens treatment and one pair of contact lenses for a Member child up to age 19 per year. Only frames from a select list of frames purchased from a Plan-approved Provider are covered. No designer frames are covered. For a list of Plan-approved frames and Providers, contact the CO-OP. Applicable Copayments and/or Coinsurance amounts are set forth in the Attachment A Benefit Schedule. Pediatric vision screenings that qualify as Preventive Services will be paid at 100% of Allowable Expenses.

5.33 Prenatal and Postnatal Care

Prenatal and postnatal services for females are covered by the Plan with no cost-sharing when provided by Plan Providers. Standard cost-sharing applies to the use of Non-Plan Providers. Coverage is provided for a standard manual or standard electric breast pump, plus necessary breast pump supplies. Coverage is available at no cost from in-network PPO providers only. Standard cost-sharing applies to the use of non-PPO providers.

SECTION 6. EXCLUSIONS

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

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

6.2 Services not provided, directed, and/or Prior Authorized by a Member's PCP and/or that require Prior Authorization by the CO-OP's Care Management Program that are provided without such Prior Authorization, except for Emergency Services and Urgently Needed Services.

6.3 Medical care received outside the CO-OP's Service Area without Prior Authorization from the CO-OP's Care Management Program if the need for such services could reasonably have been foreseen prior to leaving the CO-OP's Service Area.

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

6.5 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.

6.6 Personal comfort, hygiene or convenience items such as a hospital television, telephone, or private room when not Medically Necessary. Housekeeping or meal services as part of Home Healthcare. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

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

6.8 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.

6.9 The following infertility services and supplies are excluded, in addition to any other infertility services or supplies determined by the CO-OP not to be Medically Necessary;

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

- Sonohysterography;
- Monitoring of ovarian response to stimulants;
- CT or MRI of sella turcica unless elevated prolactin level;
- Evaluation for sterilization reversal;
- Laparoscopy;
- Ovarian wedge resection;
- Removal of fibroids, uterine septae and polyps;
- Open or laparoscopic resection, fulguration, or removal of endometrial implants;
- Surgical lysis of adhesions;
- Surgical tube reconstruction.

6.10 Reversal of surgically performed sterilization.

6.11 Elective abortions.

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

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

6.14 Third-party physical exams for employment, licensing, insurance, school, camp, sports or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings are not covered.

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

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

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

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

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

6.18 Except for pediatric vision services, 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.

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

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

6.20 Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.

- Bone anchored hearing aids are excluded except when either of the following applies:
  - For Members with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
  - For Members with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

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

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

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

6.23 Hypnosis.

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

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

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

6.27 Outpatient Prescription Drugs, nutritional supplements, vitamins, herbal medicines, appetite suppressants, Specialty drugs, and other over-the-counter drugs, except as specifically covered in the Prescription Drug benefit description. This includes drugs and supplies for a patient's use after discharge from a Hospital. Drugs and medicines approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than six (6) months unless Prior Authorized by the CO-OP.

6.28 Care for conditions that federal, state or local law requires to be treated in a public facility.

6.29 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, and other primarily nonmedical equipment.

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

6.31 Special formulas, food supplements other than as specifically covered in this EOC or special diets on an outpatient basis.

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

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

6.34 Experimental or investigational treatment or devices as determined by the CO-OP.

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

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

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

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

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

6.40 Telemetry readings, EKG interpretations when billed separately from the EKG procedure. Arterial blood gas interpretations when billed separately from the procedure.

6.41 Services of more than one (1) assistant surgeon at one (1) operative session, unless approved in advance by the CO-OP 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.

6.42 Autologous blood donations.

6.43 Healthcare services or supplies to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

6.44 Lost wages for any reason. Compensation for time spent seeking services or Coverage for services.

6.45 All shipping, delivery, handling or postage expenses, except as incidentally provided without a separate charge, in connection with Covered Services or supplies. Interest or finance expenses except as specifically required by law.

SECTION 7. LIMITATIONS

This section tells you when the CO-OP's duty to provide or arrange for services is limited.

7.1 Liability

The CO-OP 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 the CO-OP's control.

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

7.2 Calendar Year Maximum Benefit Limitations

Please see Attachment A Benefit Schedule for Calendar Year maximums applicable to certain benefits. No dollar maximums shall apply to any benefit to the extent such benefit constitutes an Essential Health Benefit.

7.3 Annual Out-of-Pocket Maximums

Please see Attachment A Benefit Schedule for the annual Out-of-Pocket Maximums that apply separately to Plan Provider and Non-Plan Provider benefits.

7.4 Scope of Practice.

A Member will be covered for services rendered due to an Injury or Illness that is within the authorized scope of practice of a licensed allied practitioner listed below so long as the practitioner is licensed pursuant to the applicable licensing laws of the Nevada Revised Statutes (NRS).

Licensed Allied Practitioners	Nevada Licensing Laws
Licensed Chiropractor	Chapter 634 of the NRS
Licensed Psychologist	Chapter 641 of the NRS
Licensed Marriage and Family Therapist	Chapter 641A of the NRS
Licensed Associate in Social Work	Chapter 641B of the NRS
Licensed Social Worker	Chapter 641B of the NRS

Licensed Independent Social Worker	Chapter 641B of the NRS
Licensed Clinical Social Worker	Chapter 641B of the NRS
Licensed Podiatrist	Chapter 635 of the NRS
Licensed Acupuncturist	Chapter 634A of the NRS
Licensed Clinical Alcohol and Drug Abuse Counselor	Chapter 641C of the NRS

A Member will be covered for the services provided by a registered nurse for services that are within the authorized scope of practice of a registered nurse who is authorized pursuant to Chapter 32 of the NRS to perform additional acts in an Emergency or under other special conditions as prescribed by the state board of nursing. However, the Plan will not cover services by any such a registered nurse if they duplicate services provided by another Provider.

SECTION 8. COORDINATION OF BENEFITS (COB)

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

8.1 The Purpose of COB

Coordination of Benefits (COB) is intended to help contain the cost of providing healthcare coverage. If, with respect to a Member covered under this policy, benefits for an allowable expense incurred during a claim determination period under this policy, together with benefits for allowable expense during such period under all other valid coverage (without giving effect to this provision or to any "coordination of benefits provision" applying to such other valid coverage), exceed the total of such individual's allowable expense during such period, the CO-OP is liable only for such proportionate amount of the benefits for allowable expense under this policy during such period as (a) the total allowable expense during such period bears to (b) the total amount of benefits payable during such period for such expense under this policy and all other valid coverage (without giving effect to this provision or to any "coordination of benefits provision" applying to such other valid coverage) less in both (a) and (b) any amount of benefits for allowable expense payable under other valid coverage which does not contain a "coordination of benefits provision."

In no event shall this section operate to increase the amount of benefits for allowable expense payable under this EOC with respect to a Member above the amount which would have been paid in the absence of this section.

8.2 Benefits Subject to COB

All of the healthcare benefits provided under this EOC are subject to this Section. The Member agrees to permit the CO-OP to coordinate its obligations under this EOC with payments under any other valid coverage.

8.3 Definitions

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

(a) "**Allowable Expense**" means 100 percent of any necessary, reasonable and customary item of expense which is covered, in whole or in part, as a hospital, surgical, medical or major medical expense under this policy or under any other valid coverage.

(b) "**Claim Determination Period**" means the each Contract Year during which allowable expense covered under this policy is incurred on account of such person.

(c) "**Coordination of benefits provision**" means this provision and any other provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage.

(d) "**Other valid coverage**" includes hospital, surgical, medical or major medical benefits provided by individual, group or family-type coverage, government programs or workers' compensation. Other valid coverage does not include automobile medical payments or third-party liability coverage.

8.4 When COB Applies

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

8.5 Right to Receive and Release Information

In order to decide if this coordination of benefits provision applies to a claim, the CO-OP (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 the CO-OP any information needed by the CO-OP to coordinate those benefits.

8.6 Facility of Payment

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

If by application of any of the coordination of benefits provision, the CO-OP effects a material reduction of benefits otherwise payable under the EOC, the insurer shall refund to the Member any unearned premium by reason of such reduction of coverage during the policy year current and that next preceding at the time the loss commenced. No such reduction of benefits or refund will be made unless the unearned premium amounts to $5 or more.

8.7 Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy the CO-OP's obligation under this section, the CO-OP has the right to recover the excess amount from the Member or the assignee or beneficiary of the Member. The amount of other valid coverage which is on a provision of service basis shall be computed as the amount the services rendered would have cost in the absence of such coverage.

8.8 Medicare

This provision describes how the CO-OP coordinates and pays benefits when a Member is also enrolled in Medicare and duplication of Coverage occurs. If a Member is not enrolled in Medicare or receiving benefits, there is no duplication of Coverage and the CO-OP does not have to coordinate with Medicare.

The benefits under this Evidence of Coverage are not intended to duplicate any benefits to which Members are entitled under Medicare. All sums payable under such programs for services provided shall be payable to and retained by the CO-OP. Each Member shall complete and submit to the CO-OP such consents, releases, assignments and other documents as may be requested by the CO-OP in order to obtain or assure reimbursement under Medicare or any other government program for which Members are eligible. In cases where Medicare or another government program has primary responsibility, Medicare benefits will be taken into account for any Member who is enrolled for Medicare. This will be done before the benefits under this Health Plan are calculated.

Charges for services used to satisfy a Member's Medicare Part B deductible will be applied in the order received by the CO-OP. Two or more charges for services received at the same time will be applied starting with the largest first.

Any rules for coordination of benefits will be applied after the CO-OP's benefits have been calculated under the rules in this provision. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

This provision will apply to the maximum extent permitted by federal or state law. The CO-OP will not reduce the benefits due any Member because of a Member's eligibility for Medicare where federal law requires that the CO-OP determine its benefits for that Member without regard to the benefits available under Medicare.

8.9 Workers' compensation

The benefits which a Member is entitled to receive under this Evidence of Coverage are not designed to duplicate any benefits to which the Member is entitled under workers'

compensation law. The CO-OP is entitled to reimbursement for any services that have been reimbursed under a workers' compensation claim.

1. Member is required to file for workers' compensation when an employment related accident, illness or injury occurs.

2. If Member's workers' compensation carrier denies a claim, Member may submit the claim to the CO-OP with a copy of the denial for consideration under this Evidence of Coverage. All plan provisions of this Evidence of Coverage will apply in the consideration process for payment under this plan.

3. Workers' compensation claims that are not a benefit under this Evidence of Coverage are not payable by the CO-OP.

4. Any benefits payable are subject to all provisions of this Evidence of Coverage, including but not limited to the Precertification requirements.

SECTION 9. GENERAL PROVISIONS

9.1 Relationship of Parties

The relationship between the CO-OP and Plan Providers is an independent contractor relationship. Plan Providers are not agents or employees of the CO-OP; nor is the CO-OP, or any employee of the CO-OP, an employee or agent of a Plan Provider. The CO-OP 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. The CO-OP is not bound by statements or promises made by its Plan Providers.

9.2 Entire Agreement

This EOC, 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 the CO-OP constitutes the entire agreement between the Member and the CO-OP and as of its Effective Date, replaces all other agreements between the parties.

9.3 Nondiscrimination

The CO-OP will not refuse to insure, refuse to enroll, refuse to continue insurance, refuse to renew insurance, cancel insurance, or limit the amount, duration or scope of Coverage or benefits available to an individual in a manner arbitrarily discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis or medical condition. This EOC provides Coverage for all Essential Health Benefits deemed Medically Necessary for a Member, without arbitrary discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, diagnosis or medical condition. If you believe the CO-OP has discriminated against you on the basis of any of these factors, you may file a complaint with the Office of Civil Rights at the Department of Health and

Human Services. For more information, see the Office of Civil Rights website at http://www.hhs.gov/ocr/civilrights/complaints/index.html.

9.4 Contestability

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

No agent or employee of the CO-OP 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 the CO-OP.

After three (3) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such three (3)-year period.

9.5 Identification Card

Cards issued by the CO-OP to Members are for identification only. Possession of a CO-OP 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.

9.6 Notice

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

Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, Nevada 89107

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

9.7 Interpretation of the EOC

The laws of Nevada shall be applied to interpretation of this EOC except to the extent federal law preempts such State laws.

9.8 Assignment

All rights of Members hereunder are personal to each Member and are not assignable or otherwise transferable except that a Member may assign his or her rights to benefits to a Provider who provided Covered Services. The CO-OP shall pay all or part of the benefits assigned by the Member to the person designated by the Member and such payment discharges the CO-OP's obligation to pay those benefits to the Member. Neither the Agreement nor any right hereunder shall be assigned, transferred or otherwise conveyed by the CO-OP without the approval of the CO-OP. If a Member desires to assign any rights hereunder, such request shall be evidenced in writing signed by the Member and will be granted or denied at the CO-OP's sole discretion. Nothing herein shall be construed to prohibit the CO-OP from engaging in a corporate reorganization or merger without the consent of the Member.

9.9 Modifications

The Plan is subject to amendment, modification or termination with sixty (60) days written notice without the consent or concurrence of the Members. By electing medical coverage with the CO-OP 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.

9.10 Clerical Error

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

9.11 Policies and Procedures

The CO-OP 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 the CO-OP at its offices. Such policies and procedures may have bearing on whether a medical service and/or supply is covered.

9.12 New Technology

The CO-OP periodically reviews new procedures, medications, treatments, and devices and new ways to use current procedures, medications, treatments, and devices to determine whether or not to update Covered Services to reflect new technology. Providers and Members may ask the CO-OP to cover new technology by submitting a written request to the CO-OP's New Technology Committee. When the CO-OP receives such a request, the CO-OP's New Technology Committee conducts a thorough investigation of the procedure, medication, treatment, or device. The CO-OP's New Technology Committee will research current related medical literature and medical practice and thoroughly discuss the findings in order to make a decision on the coverage request.

9.13 Overpayments

The CO-OP has the right to correct and/or collect benefit payments for healthcare services made in error. Hospitals, Physicians, Providers, and/or Members have the responsibility to return any overpayments or incorrect payments to the CO-OP. The CO-OP has the right to offset any such overpayment against any future payments.

9.14 Cost Containment Features

This Plan contains at least the following cost containment provisions including, but not limited to:

(a) Preventive healthcare benefits.

(b) The Care Management Program.

(c) Benefit limitations on certain services.

(d) Member Copayments, Deductibles and Coinsurance.

9.15 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 the CO-OP.

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.

9.16 Reimbursement for Claims

Non-Plan Providers may require immediate payment for their services and supplies. If the Member receives a bill for Covered Services from a Non-Plan Provider, the Member may request that the CO-OP 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 CO-OP Claims Department. Non-Plan Provider Claim Forms can be obtained by contacting the CO-OP Care Department at (702) 823-2667 or (855) 606-2667.

The CO-OP 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, the CO-OP 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.

The CO-OP may request additional information to determine whether to approve or deny the claim. The CO-OP shall notify the Provider of its request for additional information within

twenty (20) days after receipt of the claim. The CO-OP will notify the Provider of the healthcare services of all the specific reasons for the delay in approving or denying the claim. The CO-OP shall approve or deny the claim within thirty (30) days after receiving the additional information. If the claim is approved, the CO-OP 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, the CO-OP shall pay interest on the claim in the manner set forth above.

If the CO-OP 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.

9.17 Timely Filing Requirement

All claims must be submitted to the CO-OP 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 the CO-OP within twelve (12) months after the date Covered Services were provided. In no event will the CO-OP pay more than the CO-OP's Allowable Expense for such services.

9.18 Gender References

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

9.19 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.

9.20 Availability of Providers

The CO-OP does not guarantee the continued availability of any specific Plan Provider.

9.21 Authorized Representative

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

Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, Nevada 89107

Any correspondence from the CO-OP 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.

9.22 Failure to Obtain 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 provided the Member's request for Prior Authorization is received by an employee or department of the Plan customarily responsible for handling benefit matters and the original request specifically named the Member, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The Member notification of correct Prior Authorization procedures from the Plan shall be provided as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of an Urgent Care Claim) following the Plan's receipt of the Member's original request. Notification by the CO-OP may be oral unless specifically requested in writing by the Member.

9.23 Timing of Notification of Benefit Determination

Urgent Care Claim. If a Member has a claim for Urgent care and provides sufficient information to determine whether benefits are covered, the Plan will make a decision on the Claim as soon as possible and not later than 72 hours after the Plan receives the Claim. If a Member has an Urgent Care Claim and does not provide sufficient information to determine whether benefits are covered, the Member will be told within 24 hours what additional information is needed to decide the Claim. The Member will then have at least 48 hours to provide the additional information.

The Plan will notify the Member of its decision as soon as possible and within 48 hours after (1) all necessary information is provided, or (2) the 48 hours the Member has in which to provide the necessary information ends, whichever is sooner.

In general, an "Urgent Care Claim" is a Claim for which using the usual Claim determination period could seriously jeopardize the life or health of the claimant.

Concurrent Care Claim. If the CO-OP 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, the CO-OP 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. The CO-OP 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.

Pre-Service Claim. If a Member makes a Claim for benefits before receiving the benefits, and it is neither an Urgent Care Claim or a Concurrent Care Claim, the Claim will be decided within a reasonable time no longer than 15 days after receipt of the Claim. However, an additional 15 days may be needed if there are special circumstances beyond the Plan's control. If so, the Member will be given notice of the special circumstances before the end of the first 15 days and told whether additional information is needed to decide the claim. The Member will have at least 45 days to provide the additional information. Keep in mind that only where Prior Authorization is required will such a request prior to receiving benefits be an official Claim.

The Plan will notify the Member if a request for Prior Authorization is not sufficient to be a Claim as soon as possible, but in any event not later than five (5) days (24 hours in a case of an Urgent Care Claim), and tell the Member how to submit a proper claim for prior approval of treatment.

Post-Service Claims. If a Member makes a Claim for benefits after receiving the treatment, and it is neither an Urgent Care Claim or a Concurrent Care Claim, the Claim will be decided within a reasonable time, no longer than 30 days after receipt of the Claim. However, an additional 15 days may be needed if there are special circumstances beyond the Plan's control. If so, the Member will be given notice of the special circumstances before the end of the first 30 days and told whether additional information is needed to decide the Claim. The Member will have at least 45 days to provide the additional information.

9.24 Notification of an Adverse Benefit Determination

If you receive an Adverse Benefit Determination, you will be provided in writing information sufficient to identify the claim involved and informed in writing of the following:

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- The date of service;
- The name of the health care provider;
- The claim amount;
- Notification that you may request, and the Plan will provide upon request, the diagnosis code and treatment code along with the corresponding meaning of such codes;
- The reason for the Adverse Benefit Determination, including any denial code, corresponding meaning of such code and a description of the Plan's standard, if any, that was used in denying the claim, and, for a final Adverse Benefit Determination Notice, a discussion of the Plan's decision;
- 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;
- If the denial relates to a claim involving urgent care, a description of the expedited review process applicable to such claim;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- 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 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.
- Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist with internal claims and appeals and external review processes.

SECTION 10. APPEALS PROCEDURES

The CO-OP 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. Also, appeals procedures with respect to an eligibility determination are set forth in Section 10.8.

Concerns about medical services are best handled at the medical service site level before being brought to the CO-OP. If a Member contacts the CO-OP 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.

Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at the time are also subject to these procedures. Medical coverage for you and your Dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity to review.

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 CO-OP Care 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.

Formal Appeal: An appeal of an Adverse Benefit Determination filed in writing which the CO-OP's Advocacy Department investigates. If a Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The Formal Appeal is mandatory if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.

Advocacy Committee: A committee in which the majority of those individuals who are voting members must be members of a CO-OP Health Benefit Plan.

CO-OP Care Crew Member: An employee of the CO-OP that is assigned to assist the Member or the Member's Authorized Representative in filing a grievance with the CO-OP or appealing an Adverse Benefit Determination.

10.1 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 the CO-OP Care 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 CO-OP Care Department 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 CO-OP membership number; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

A CO-OP Care Crew Member will inform the Member that upon review and investigation of the relevant information, the CO-OP 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 Formal Appeal.

10.2 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 Formal Appeal. The Formal Appeal must be submitted in writing to the CO-OP's Advocacy 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 in Section 10.1. Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit Determination to which they relate.

The 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 CO-OP membership number; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the Member feels that the Adverse Benefit Determination was wrong.

Additionally, the Member may submit any supporting medical records, Physician's letters, or other information that explains why the CO-OP should approve the Claim for Benefits. The Member can request the assistance of an Advocacy Department Representative at any time during this process. You may obtain copies of any related Plan records. You have the right to review your file and present evidence as part of the review. No deference will be given to the initial Claim denial. Your appeal will be decided by an individual(s) who did not take part in the Claim denial and who is not subordinate of such a person. The Advocacy Department Representative will ensure that there is no conflict of interest with regard to the individual making the decision.

If your Claim involves a medical judgment, a health care professional trained in the relevant field will be consulted; one who did not take part in the Claim denial and who is not the subordinate of such a person. You may also request the names of medical professionals who gave advice on your Claim denial.

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

Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, Nevada 89107
Fax: (702) 802-4601

The Advocacy Committee shall:

- consider the Appeal;
- 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 the CO-OP's receipt of the request for a Formal Appeal

This period may be extended one (1) time by the CO-OP for up to fifteen (15) days, provided that the extension is necessary due to matters beyond the control of the CO-OP and the CO-OP 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 the CO-OP expects to render a decision. If the extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Member shall be afforded at least forty-five (45) days from receipt of the notice to provide the information.

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

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- Any new or additional rationale and/or evidence considered, relied on, or generated by the Plan (or at the direction of the Plan) in connection with your claim. You will receive this rationale and/or evidence sufficiently in advance of the date on which the notice of the adverse benefit determination is required in order to give you a reasonable opportunity to respond prior to that date;
- 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;
- If any internal rule, guideline, protocol or other similar criterion was used in the appeal denial, you will be told about it and may have a copy of it.

- A statement describing any voluntary appeal procedures offered by the CO-OP and the Member's right to receive additional information describing such procedures;
- If the Adverse Benefit Determination is based on Medical Necessity or experimental 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).
- A statement describing the Member's External Appeals Rights, if applicable, or judicial review.

Limited extensions may be required if additional information is required in order for the CO-OP to reach a resolution.

The CO-OP will maintain records of all claims and notices associated with the internal claims and appeals process, including the information detailed above and any other information required by law for six years. The CO-OP will make such records available for examination by the claimant or State or Federal oversight agency upon request.

10.3 Expedited Appeal

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

If insufficient information is received, the CO-OP 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. The CO-OP 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:

- the CO-OP'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 or attending provider 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, the CO-OP will automatically grant an Expedited Appeal.

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

10.4 Arbitration of Disputes of an Independent Medical Review

If the Member is dissatisfied with the findings of an Independent Medical Review, the Member shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association.

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

10.5 External Review

The CO-OP offers to the Member or the Member's Authorized Representative the right to an External Review of an Adverse Benefit Determination. For the purposes of this section, a Member's Authorized Representative is person to whom a Member has given express written consent to represent the Member in an External Review of an Adverse Benefit 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 Benefit Determinations eligible for External Review set forth in this section are only those relating to a rescission of coverage or Medical Necessity, appropriateness of service, healthcare service, healthcare setting, or level of care or effectiveness of a healthcare service. The CO-OP will provide the Member notice of such an Adverse Benefit Determination which will include the following statement:

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

Additionally, as per applicable law and regulations, the notice will provide the Member the information outlined in Section 10.2 as well as the following:

- The telephone number for the Office for Consumer Health Assistance for Nevada.
- 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 the CO-OP 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 Benefit Determination by an Independent Review Organization ("IRO") within four (4) months of the Member or the Member's Authorized Representative receiving notice of such determination. The IRO must be certified by the Nevada Division of Insurance. Requests for an External Review must be made in writing and submitted to OCHA at the address below and should include the signed HIPAA authorization form, authorizing the release of your medical records. Your written request should include:

a. A specific request for an external review;

b. your name, address, and member ID number;

c. your designated representative's name and address, when applicable;

d. the service that was denied; and

e. any new, relevant information that was not provided during the internal appeal.

The entire External Review process and any associated medical records are confidential.

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

The determination of an IRO concerning an External Review in favor of the Member of an Adverse Benefit Determination is final, conclusive and binding. Upon receipt of the notice of a decision by the IRO reversing an Adverse Benefit Determination, the CO-OP shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Benefit Determination. The cost of conducting an External Review of an Adverse Benefit Determination will be paid by the CO-OP.

10.5.a Standard External Review

The Member may submit a request for an External Review of an Adverse Benefit Determination under this section only after the Member has exhausted all applicable internal CO-OP Appeals Procedures provided under this Plan and if the CO-OP 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 the CO-OP agrees to permit the Member to submit the Adverse Benefit Determination to OCHA

without requiring the Member to exhaust all internal CO-OP Appeals Procedures. The Member may request an external review only after completing the Plan's internal claims and appeals procedures, unless the Plan fails to strictly adhere to all of the requirements of the internal claims and appeals process with respect to the Member's medical claim. In such case, the Member is deemed to have exhausted the internal claims and appeals process and the Member may seek an external review or pursue legal remedies. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the Member may resubmit his or her claim for internal review and the Participant may ask the Plan to explain why the error is minor and why it meets this exception.

Within five (5) days after OCHA receives a request for External Review, OCHA shall notify the Member, the Member's Authorized Representative and the CO-OP 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, the CO-OP shall provide to the selected IRO all documents and materials relating to the Adverse Benefit Determination, including, without limitation:

- Any medical records of the Member relating to the Adverse Benefit Determination;
- A copy of the provisions of the healthcare Plan upon which the Adverse Benefit Determination was based;
- Any documents used and the reason(s) given by the CO-OP's Care Management Program for the Adverse Benefit 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 Benefit Determination.

Within five (5) days after the IRO receives the required documentation from the CO-OP, 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 the CO-OP within one (1) business day after receipt.

The IRO shall approve, modify, or reverse the Adverse Benefit 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
- the CO-OP.

10.5.b Expedited External Review

A request for an Expedited External Review may be submitted to OCHA after it receives proof from the Member's Provider that the Adverse Benefit 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. The CO-OP will supply all relevant medical documents and information used to establish the Adverse Benefit 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 the CO-OP 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 or attending provider;
- Member's Authorized Representative, if any; and
- the CO-OP.

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

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

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

10.6.a Standard External Review

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

OCHA will notify the CO-OP 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 the CO-OP receives such notice and, subject to applicable Nevada law and regulation and pursuant to this section, the CO-OP 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, the CO-OP will notify in writing, the Member or the Member's Authorized Representative and OCHA, accordingly. If the CO-OP determines that the case is incomplete and/or ineligible, the CO-OP 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 the CO-OP's determination that a request for External Review of an Adverse Benefit 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 the CO-OP, OCHA will assign the IRO accordingly and notify in writing the Member or the Member's Authorized Representative and the CO-OP that the request is complete and eligible for External Review and provide the name of the assigned IRO. The CO-OP, 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 Benefit 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 Benefit 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
- the CO-OP.

10.6.b Expedited External Review

The Member or the Member's Authorized Representative may request in writing an internal Expedited Appeal by the CO-OP and an Expedited External Review from OCHA simultaneously if the Adverse Benefit Determination of the requested or recommended service or treatment is determined by the CO-OP to be experimental or investigational, and, if the treating

provider certifies, in writing, that such service or treatment would be less effective if not promptly initiated.

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

The CO-OP 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 the CO-OP 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 the CO-OP. The IRO has one (1) business day to select one or more clinical reviewers. The CO-OP must submit the documentation used to support the Adverse Benefit Determination to the IRO within five (5) business days. If the CO-OP fails to provide the information within the specified time, the IRO may terminate the External Review and reverse the Adverse Benefit 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 the CO-OP 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
- the CO-OP.

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

10.7 Office for Consumer Health Assistance

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

10.8 Appealing a Marketplace Decision

If you don't agree with certain decisions made by the Marketplace, you may be able to file an appeal.

You can appeal the following kinds of Marketplace decisions:

- whether you're eligible to buy a Marketplace plan;
- whether you can enroll in a Marketplace plan outside the regular open enrollment period;
- whether you're eligible for lower costs based on your income;
- the amount of savings you're eligible for;
- whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP);
- whether you are eligible for an exemption from the individual responsibility requirement; or
- your eligibility notice.

When you apply for coverage in the Marketplace, you'll get an eligibility notice that explains what you qualify for. It will provide appeals instructions for each person in your household, including the number of days you have to file an appeal.

You can have someone else file or participate in your appeal. That person can be a friend, relative, lawyer, or other person. Or you can handle the appeal yourself. If you file an appeal, you may be able to keep your eligibility for coverage while your appeal is pending. You'll get a letter that describes your options. The outcome of an appeal could change the eligibility of other members of your household.

Your eligibility determination letter will explain how to file an appeal. In general, you can appeal your eligibility results by mailing an appeal request form available on the Marketplace at https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ or writing a letter to:

Health Insurance Marketplace
465 Industrial Blvd.
London, KY 40750-0061

After you file an appeal, you will receive a letter that confirms receipt of the appeal, provides a description of the appeals process and includes instructions for submitting additional material for consideration, if necessary

While your appeal is being processed, you may get a letter from the Marketplace asking for more information or documentation, like a copy of a passport. If you send this information, the Marketplace may be able to informally resolve your case fairly quickly. In general, the Marketplace must issue a decision and mail a response within 90 days of receipt of your appeal request.

You can file a request for an expedited (faster) appeal if the time needed for the standard appeal process would jeopardize your life or your ability to attain, maintain, or regain maximum function. Your request to expedite your appeal should specifically explain how a standard appeal would jeopardize your life or your ability to attain, maintain, or regain maximum function. Your request to expedite your appeal will be processed as quickly as possible. A final decision must be made as quickly as your situation requires.

Navigators may assist you in filing an appeal and may answer questions about the appeals process. A Navigator is someone who can provide unbiased help when you submit an appeal. He or she may also refer you to another person or organization that can help you. Find a Navigator in your area. You can also appoint an authorized representative to help you. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you. You can appoint an authorized representative by completing an "Appointment of Representative" form available at Healthcare.gov or by submitting a written request with your appeal that includes a statement appointing someone as your representative and the representative's contact information and a statement authorizing the release of your personal and identifiable information to your representative and explaining why you're being represented. Your representative should sign and date the request as well.

You have the right to get help and information about appeals and other Marketplace issues in your language at no cost. To talk to an interpreter, call 1-800-318-2596.

SECTION 11. GLOSSARY

11.1 "**Advance Payment Tax Credit**" or "APTC" means a payment made monthly on your behalf by the Federal government under Internal Revenue Code Section 36B directly to a selected insurance carrier thereby decreasing your monthly premium payment.

11.2 "**Adverse Benefit Determination**" means a rescission of coverage; a decision by the CO-OP 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 limitation on an otherwise Covered Service; or a determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate. A denial of coverage in an initial eligibility determination for individual coverage is an Adverse Benefit Determination.

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.

11.3 "**Allowable Expenses**" means the maximum amount the CO-OP will pay for a particular Covered Service as determined by the CO-OP in accordance with the CO-OP's Reimbursement Schedule. Allowable Expenses are subject to Deductibles, Copayments, Coinsurance, and Plan limits. The Plan pays no more than the Allowable Expense or the actual billed charges, whichever is less. However, the amount actually paid by the Plan may be a percentage of the Allowable Expense. The Plan has the sole, complete and final authority and discretion in determining Allowable Expense. Allowable Expense is determined according to the following method:

(a) Plan Provider Services: Except as may be otherwise specified in the Plan, to the extent benefits are paid pursuant to an agreement or contract between the Plan and a Provider, the Allowable Expense is the rate, amount, or schedule stated in such agreement or contract.

(b) Non-Plan Provider Services: Except as may be otherwise specified in the Plan, for covered services and supplies provided by a Non-Plan Provider, the Allowable Expense is (1) the negotiated rate between the Plan and the Provider, or (2) the Plan's rate or schedule, or percentage thereof, for such Covered Services or supplies, whichever is less, as determined in the sole, exclusive, and final judgment of the Plan, or (3) such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of Section 2719A(b) of the Public Health Service Act, as amended, and related federal guidance, as determined in the sole, exclusive and final judgment of the Plan.

11.4 "**Ambulance**" means a vehicle licensed to provide Ambulance services.

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

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

11.6 "**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.

11.7 "**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 Benefit Determination, or in obtaining an External Review of an Adverse Benefit Determination. The designation must be in writing unless the claim or appeal involves an Urgent Care Claim and a healthcare professional with knowledge of the

Member's medical condition is seeking to act on the Member's behalf as his Authorized Representative.

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

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

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

11.11 "**Care Management 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.

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

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

11.13 "**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).

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

11.15 "**CO-OP Reimbursement Schedule**" means the schedule showing the amount the CO-OP will pay for Allowable Expenses. It 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 the CO-OP determines to be similar in complexity and nature with reference to other industry and governmental sources.

For Non-Plan Provider Emergency Services, the CO-OP will pay the greater of: (1) the amount it has negotiated with Plan Providers for the Emergency Services received (and if there is more than one amount, the median of the amounts); (2) 100% of the Allowable

Expense for Emergency Services provided by a Non-Plan Provider under your Plan; (3) or the amount that would be paid for the Emergency Services under Medicare.

11.16 "**Coinsurance**" means the percent of an Allowable Expense, after the Calendar Year Deductible, that the Member must pay for Covered Services. Coinsurance amounts are shown in Attachment A Benefits Schedule.

11.17 "**Contract Year**" means the twelve (12) months beginning with and following the Effective Date.

11.18 "**Contracting Pharmacy**" means a pharmacy that has a contract with the Plan to provide Drug services to Members.

11.19 "**Copayment**" means the amount the Member pays when a Covered Service is received. Copayment amounts are shown in Attachment A Benefits Schedule.

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

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

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

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

11.23 "**Dependent**" means an Eligible Dependent 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 the CO-OP.

11.24 "**Domestic Partner**" means an individual whose Domestic Partnership with an Subscriber is recognized by the State of Nevada (www.nvsos.gov). Under this Plan, a Domestic Partner is not also considered to be a spouse.

11.25 "**Drug**" means any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, only upon written or oral prescription of a physician or healthcare practitioner licensed by law to administer it.

11.26 "**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.

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

11.28 "**Eligible Dependent**" means an individual who is or becomes eligible to enroll for coverage under this Plan as a Dependent.

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

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

11.30 "**Enrollment Date**" means the first day of coverage under this Plan.

11.31 "**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.

11.32 "**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 the CO-OP.

11.33 "**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.

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

11.35 "**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.

11.36 "**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.

11.37 "**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.

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

11.39 "**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.

11.40 "**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.

11.41 "**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.

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

is licensed by the state where it is located and is Medicare-certified;

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

Hospital does not include:

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

11.43 "**Hospitalist Program**" means the program that provides Hospital inpatient Physician services to Members. The Hospitalist Program utilizes licensed non-specialist Hospital-based Physicians who have directly contracted with the Plan or with the Health Services Coalition on behalf of the Plan. Use of designated Hospitalist Program physicians for inpatient care is required for all Members. Members receiving care through the Hospitalist Program will have no out of pocket expenses such as Deductibles, Coinsurance and Copayments for the covered services by designated Hospitalist Program physicians. Physician care by specialists such as OB/GYN and pediatricians will continue to be covered and paid as normal under the Plan rules, since specialists are not part of the Hospitalist Program.

11.44 "**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.

11.45 "**Independent Medical Review**" means an independent evaluation of the medical or chiropractic care of a Member that must include a physical examination of the Member unless he is deceased, and a personal review of all x-rays and reports by a certified Physician or Chiropractor who is formally educated in the applicable medical field.

11.46 "**Independent Review Organization**" means an entity that:

- Conducts an independent External Review of an Adverse Benefit Determination; and
- Is certified by the Nevada Commissioner of Insurance

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

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

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

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

11.51 "**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.

11.52 "**Marketplace**" means the federal health insurance exchange at Healthcare.gov.

11.53 "**Medical Director**" means a Physician named by the CO-OP to review use of health services by Members.

11.54 "**Medically Necessary**" means health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, physician, or other health care provider; and
- not generally regarded as experimental, investigational, or unproven by any government agency having appropriate jurisdiction, including, but not limited to, the Food and Drug Administration or the Office of Health Technology Assessment, the organized medical community in the United States, or in accordance with the standards and procedures utilized by the Plan to determine whether such treatments, procedures, services or supplies are experimental or investigational, the terms of which are adopted and incorporated herein.

In determining whether a service or supply is Medically Necessary, the CO-OP 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 the CO-OP.

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.

11.55 "**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.

11.56 "**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 the CO-OP.

11.57 "**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:

- Marital or family problems;
- Social, occupational, or religious maladjustment;
- Behavior disorders;
- Impulse control disorders;
- Learning disabilities;
- Mental retardation;
- Chronic organic brain syndrome;
- Personality disorder; or
- Transsexualism, psychosexual identity disorder, psychosexual dysfunction of gender dysphoria.

11.58 "**Non-Plan Provider**" means a Provider who does not have an independent contractor agreement with the CO-OP.

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

11.60 **"Open Enrollment Period"** means an annual thirty-one (31) day period of time during which Eligible Subscribers and their Eligible Dependents may enroll under this Plan.

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

11.62 "**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.

11.63 "**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.

11.64 "**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 the CO-OP.

11.65 "**Plan Provider**" means a Provider who has an independent contractor agreement with the CO-OP to provide certain Covered Services to Members. A Plan Provider's agreement with the CO-OP may terminate, and a Member will be required to select another Plan Provider in order to continue receiving Plan Provider benefits.

11.66 "**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.

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

11.68 "**Prescription Drug**" means any required by federal law or regulation to be dispensed only by a prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

11.69 "**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.

11.70 "**Primary Care Physician**" or "**PCP**" means a Plan Provider who has an independent contractor agreement with CO-OP to assume responsibility for arranging and coordinating the delivery of Covered Services to Members. A Primary Care Physician's agreement with CO-OP 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.

11.71 "**Prior Authorization**" or "**Prior Authorized**" means a system that requires a Provider to get approval from the CO-OP 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.

11.72 "**Procurement**" means obtaining Medically Necessary human organs or tissue for a Covered Transplant Procedure as determined by the CO-OP 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.

11.73 "**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.

11.74 "**Provider**" means a

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

11.75 "**Qualified Health Plan**" or "QHP" means a qualified health plan as defined at 42 USC § 18021.

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

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

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

11.79 "**Service Area**" means the geographic area serviced by the CO-OP as authorized by the State of Nevada, and designated by the CO-OP for the provision of Covered Services. These areas may change from time to time as designated by the CO-OP. Dependent children that are covered under this Plan, due to a court order, do not have to reside within the CO-OP's Service Area.

11.80 "**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), published by the American Psychiatric Association:

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

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

11.82 "**Short-Term Habilitation and Rehabilitation**" means Inpatient or outpatient habilitation services and 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.

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

11.84 "**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.

11.85 "**Specialist Physician**" or "**Specialist**" means a Plan Provider who has an independent contractor agreement with the CO-OP 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 Plan Specialist Physician's agreement with the CO-OP may terminate. In the event that a Member's Plan Specialist Physician's agreement terminates, another Plan Specialist Physician will be selected for the Member if those services are still required.

11.86 "**Specialty Drugs**" are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by the CO-OP that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.

11.87 "**Subscriber**" means an individual 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 the CO-OP.

11.88 "**TeleHealth**" means the delivery of preventive, promotive and curative health-related services and information via telecommunications technologies. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

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

11.90 "**Transplant Benefit Period**" means the period beginning with the date the Member receives a written Referral from the CO-OP 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.

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

11.92 "**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.

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

11.94 "**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.

SECTION 12. OTHER NOTICES

12.1 Mothers and Newborns

Health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

12.2 Women's Cancer Rights

A Federal law called the Women's Health and Cancer Rights Act of 1998 became effective for this Plan on September 1, 1999. Under this law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or Beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

If you have any questions about Plan coverage of mastectomies or reconstructive surgery, please call (702) 823-2667 or (855) 606-2667.

12.3 Mental Health Parity

This Plan complies with federal law, which generally does not permit annual or lifetime dollar limits for mental health benefits to be lower than those that apply to medical benefits. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that the financial requirements for Coinsurance and Copayments as well as other quantitative and qualitative limits for mental health and substance use disorder conditions must be no more restrictive than those requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that Coinsurance or Copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.