PLAN BENEFIT INFORMATION

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Plan Benefit Information

Index

Health Plan of Nevada, Inc. has been awarded an accreditation status of Commendable from the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare. Accreditation is for the Commercial HMO, Commercial POS and Medicare HMO product lines in Nevada effective May 2006.

Your *Health Plan of Nevada* Reference Guide

Your complete Plan Benefit Information packet includes your Evidence of Coverage, Attachment A Benefit Schedule, applicable Riders and Endorsements. These documents explain in detail your benefits, rights and responsibilities as a Health Plan of Nevada Member. It also outlines the health plan's obligations to you. We encourage you to read all materials carefully, because the more you know about us, the better we can serve you.

Our Philosophy

Health Plan of Nevada is committed to high standards of professional ethics and to the principle that our members come first. We are a caring team of healthcare professionals, dedicated to improving the quality of life and health of the people we serve.

HPN@YourService Online Member Center

With Health Plan of Nevada, you have access to this exciting online member center. You'll be surprised how easy it is to get answers to your claims and benefit questions, as well as access some service features. And, because access is through your computer, HPN@YourService[SM] is available 24 hours a day/7 days a week. Highlights include such functions as:

- Changing your address
- Requesting a new ID card
- Finding out what coverage you have for pharmacy services
- Looking at your copayment amounts for medical services
- Reviewing the status of your claim
- Finding out who is on record as your Primary Care Provider (PCP)
- Checking if your prior authorization request has been received by the health plan
- Inquiring as to how much you have applied toward your calendar year deductible
- And much more!

Visit us at www.healthplanofnevada.com. Member medical information is confidential and only available to members and their providers.

Rights & Responsibilities

Health Plan of Nevada is committed to ensuring that members are treated in a manner that respects their rights and promotes effective healthcare. Health Plan of Nevada has also identified its expectations of members' responsibilities in this joint effort. Health Plan of Nevada's statement regarding Members' Rights and Responsibilities includes the following:

Member's Rights

1. To be treated with respect and dignity and every effort made to protect your privacy.
2. To select a primary care physician from HPN's extensive provider list including the right to refuse care from specific practitioners.
3. To be provided the opportunity to voice complaints or appeals about the plan and/or the care provided.
4. To receive information about the plan, its services, its providers, and members' rights and responsibilities.
5. To participate with your primary care physician in the decision making process regarding your healthcare.

6. To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
7. To have direct access to women's health services for routine and preventive care.
8. To have direct access to medically necessary specialist care in conjunction with an approved treatment plan developed with the primary care physician. Required authorizations should be for an adequate number of direct access visits.
9. To have access to emergency healthcare services in cases where a "prudent layperson" acting reasonably, would have believed that an emergency existed.
10. To formulate Advance Directives.
11. To have access to your medical records in accordance with applicable state and federal laws.
12. To make recommendations regarding the organization's members' rights and responsibilities policies.

Member's Responsibilities

1. To know how HPN's Managed Care Program operates.
2. To provide, to the extent possible, information that HPN and its providers need in order to provide the best care possible.
3. To take responsibility for maximizing health habits and to follow the healthcare plan that you, your physician and HPN have agreed upon.
4. To consult your primary care physician and HPN before seeking non-emergency care in the service area. We urge you to consult your physician and HPN when receiving urgently needed care while temporarily outside the HPN service area.
5. To obtain a written referral from your physician before going to a specialist, unless you are utilizing Point-of-Service benefits or the Specialist Direct option.
6. To obtain prior authorization from HPN and your physician for any routine or elective surgery, hospitalization, or diagnostic procedures.
7. To be on time for appointments and provide timely notification when canceling any appointment you cannot keep.
8. To pay all applicable copayments at the time of service.
9. To avoid knowingly spreading disease.
10. To recognize the risks and limitations of medical care and the healthcare professional.
11. To be aware of the healthcare provider's obligation to be reasonably efficient and equitable in providing care to other patients in the community.
12. To show respect for other patients, healthcare providers and plan representatives.
13. To abide by administrative requirements of HPN, healthcare providers, and government health benefit programs.
14. To report wrongdoing and fraud to appropriate resources or legal authorities.
15. To know your medications. Keep a list and bring it with you to your appointment with your primary care provider.
16. To address medication refill needs at the time of your office appointment. When you obtain your last refill, notify the office that you will need refills at that time. Do not wait until you are out of your medication.
17. To report all side effects of medications to your primary care provider. Notify your primary care provider if you stop taking your medications for any reason.
18. To ask questions during your appointment time regarding physical complaints, medications, any side effects, etc.
19. To participate in understanding their health problems and developing mutually agreed upon treatment goals.

Important Telephone Numbers And Addresses:

Member Services

P.O. Box 15645

Las Vegas, NV 89114-5645

(702) 242-7300 or (800) 777-1840

8AM – 5 PM Monday through Friday

Claims Administration

P.O. Box 15645

Las Vegas, NV 89114-5645

Telephone Advice Nurse

(702) 242-7300 or (800) 288-2264

Health and Wellness Education

(702) 877-5356

Behavioral Healthcare Options

(702) 364-1484 or (800) 873-2246

Southwest Medical Associates

Scheduling Center & Same-Day Access Program

(702) 877-5199

List Your Own:

Doctor Name: _____
Address: _____
Telephone: _____

Doctor Name: _____
Address: _____
Telephone: _____

Doctor Name: _____
Address: _____
Telephone: _____

Doctor Name: _____
Address: _____
Telephone: _____

Doctor Name: _____
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Doctor Name: _____
Address: _____
Telephone: _____

Doctor Name: _____
Address: _____
Telephone: _____

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HEALTH PLAN OF NEVADA, INC.℠

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Notice to Members

This is to provide notice as required under recent federal law

(the Women's Health and Cancer Rights Act, effective October 21, 1998).

Under this health plan, coverage will be provided to a member who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

1. reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the covered patient, and will be subject to the same terms and conditions of your evidence of coverage, including any required copayments, annual deductibles or coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and corresponding reconstructive surgery, please contact the Member Services number on the back of your ID card.

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Effective Date April 14, 2003

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

If you have any questions about this notice, please contact Member Services at (702) 242-7300 or 1-800-777-1840. Senior Dimensions members may contact us at (702) 242-7301 or 1-800-650-6232; TDD/TTY (702) 242-9214 or 1-800-349-3538, Monday through Friday, 8 a.m. to 5 p.m.

Who Will Follow This Notice

This notice describes the privacy practices of Health Plan of Nevada, Inc. and of any third parties that assist it in the performance of its duties involving the use of your Protected Health Information (PHI).

Our Pledge Regarding Your Protected Health Information

When we say "Protected Health Information" or "PHI" we mean: information created or received by a healthcare provider, health plan, or employer that relates to your past, present, or future physical or mental health or condition, the provision of healthcare to you; or the past, present, or future payment for your healthcare. The information must also identify you or be the type that could reasonably be used to identify you.

We understand that your PHI is personal. We are committed to protecting that information. This notice applies to all of the PHI we maintain. Your personal doctor or healthcare provider may have different policies or notices regarding his or her use and disclosure of your PHI created in his or her office or clinic.

This notice tells you about the ways we may use and disclose your PHI. It also describes our obligations and your rights regarding use and disclosure of your PHI.

We are required by law to:

- make sure that your PHI is kept private;
- give you this notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of this notice for as long as it remains in effect.

How We May Use and Disclose Your Protected Health Information

The following categories describe different ways that we use and disclose PHI. We explain each type of use or disclosure and present some examples. Not every use or disclosure is listed. All of the ways we are permitted to use and disclose information will, however, fall within one of the categories.

We may not make a use or disclosure of your PHI that does not fall within one of these categories unless we first receive your written authorization.

- **For Treatment**

  We may use or disclose your PHI to facilitate medical treatment or services by healthcare providers. We may disclose your PHI to healthcare providers, including doctors, nurses, technicians, medical students, or other medical personnel who are involved in taking care of you. For example, we may disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription may be harmful to you.

- **For Payment**

  We may use and disclose your PHI to determine your eligibility for plan benefits, to facilitate payment for treatment and services you receive from healthcare providers, to determine benefit responsibility under the plan, or to coordinate benefits with other coverage you may have. For example, we may tell your healthcare provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the plan will cover the cost of the treatment. We may also share your PHI with another health plan to coordinate benefit payments.

- **For Healthcare Operations**

  We may use and disclose your PHI for healthcare operations. These uses and disclosures are necessary to manage the plan. For example, we may use your PHI for conducting quality assessment and improvement activities; underwriting; premium rating; submitting claims for stop loss coverage; conducting or arranging for medical review; legal services; audit services; fraud and abuse detection programs; and business planning and development and general administrative activities.

- **To Keep You Informed**

  We may use your PHI to contact you so that we can remind you of appointments, describe or recommend treatment alternatives, or to give you information about health-related benefits that may be of interest to you. For example, if we offer educational classes on how to live with diabetes, we may contact you to inform you of that class if our records show that you have diabetes.

- **As Required By Law**

  We will disclose your PHI when we are required to do so by federal, state or local law. For example, we may disclose your PHI when required to do so by a court order in a litigation proceeding such as a medical malpractice action.

- **To Avert a Serious Threat to Health or Safety**

  We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure of this type, however, would only be made to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

- **Disclosure to Health Plan Sponsor**

  Your PHI may be disclosed to another health plan maintained by your employer for purposes of facilitating claims payment under that plan. In addition, your PHI may be disclosed to personnel of your employer solely for the purpose of administering benefits under your group health plan.

- **Organ and Tissue Donation**

  If you are an organ donor, we may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans**

  If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may also disclose PHI about foreign military personnel to the appropriate military authority.

- **Workers' Compensation**

  We may disclose your PHI for workers' compensation or similar program activities. These programs provide benefits for work-related injuries or illnesses.

- **Public Health Risks**

  We may disclose your PHI for public health activities. These activities generally include the following:

  - to prevent or control disease or injury;
  - to report births and deaths;

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when we are required by law to do so.

- **Health Oversight Activities**

  We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**

  If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement**

  We may disclose your PHI if asked to do so by a law enforcement official:

  - in response to a court order, subpoena, warrant, summons or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - about a death we believe may be the result of criminal conduct;
  - about criminal conduct on our premises; and
  - in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the persons who committed the crime.

- **Coroners, Medical Examiners, and Funeral Directors**

  We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your PHI to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities**

  We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Inmates**

  If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may disclose your PHI to the correctional institution or law enforcement official. This disclosure would be necessary:

  - for the institution to provide you with healthcare;
  - to protect your health and safety or the health and safety of others; or
  - for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your PHI that may be used to make decisions about you. To inspect and copy this PHI, you must make your request in writing to Health Plan of Nevada, Customer Response and Resolution Department, P. O. Box 15645, Las Vegas, NV 89114-5645. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain, limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed.

Right to Amend

If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us.

Your request for amendment must be made in writing and submitted to Health Plan of Nevada, Customer Response and Resolution Department, P. O. Box 15645, Las Vegas, NV 89114-5645. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of your PHI that we maintain;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you are permitted to inspect or copy; or
- is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" listing any disclosure of your PHI made for any purpose other than treatment, payment, or healthcare operations. We have 60 days to respond to your written request for an accounting of disclosures. We may take an additional 30 days (giving us a total of 90 days to respond) in certain circumstances. In order to take the extra 30 days, we must notify you of that within the original 60 day time frame.

To request an accounting of disclosures, you must make your request, in writing, to Health Plan of Nevada, Customer Response and Resolution Department, P. O. Box 15645, Las Vegas, NV 89114-5645. Your request must state a time period which may not be longer than 6 years and may not include dates before April, 2003. The first list you request in any 12 month period will be provided to you for free. For other lists in the same 12 month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or change your request at that time, before you incur any costs.

Right to Request Restrictions

You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to Health Plan of Nevada, Customer Response and Resolution Department, P. O. Box 15645, Las Vegas, NV 89114-5645. In your request you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply, for example, you may want to limit disclosures of your PHI to your spouse.

Right to Request Confidential Communications

You have the right to request that our communications with you involving your PHI be carried out in a certain way or at a certain location. For example, you may ask that we contact you only at work.

To request confidential communications, you must make your request, in writing, to Health Plan of Nevada, Customer Response and Resolution Department, P. O. Box 15645, Las Vegas, NV 89114-5645. We may ask you the reason for your request. Your request must specify how or where you wish to be contacted.

We are not required to agree to your request.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically (via e-mail), you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, www.healthplanofnevada.com.

To obtain a paper copy of this notice, please contact Member Services at (702) 242-7300 or 1-800-777-1840. Senior Dimensions members may contact us at (702) 242-7301 or 1-800-650-6232; TDD/TTY (702) 242-9214 or 1-800-349-3538, Monday through Friday, 8 a.m. to 5 p.m.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any PHI we receive in the future. We will post a copy of the current notice on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Health Plan of Nevada, Customer Response and Resolution Department, P. O. Box 15645, Las Vegas, NV 89114-5645. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Other Uses of Protected Health Information

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reason covered by your written authorization.

You understand that we are unable to take back any disclosures we have already made with your authorization and that we are required to keep certain records in our files even if you leave our health plan.

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ENDORSEMENT 2008

TO THE HPN EVIDENCE OF COVERAGE
AND ATTACHMENT A, BENEFIT SCHEDULE

This Endorsement is a supplement to your Health Plan of Nevada, Inc. ("HPN") Evidence of Coverage ("EOC") and Attachment A, Benefit Schedule. Subject to the applicable terms, conditions, limitations and exclusions stated in the EOC, Attachment A, Benefit Schedule and this Endorsement, the following provision is hereby included in your healthcare coverage on July 1, 2007 or your Effective Date of coverage, whichever occurs later:

HPN Evidence of Coverage

In addition to the services currently listed in the Preventive Healthcare Services Section, Covered Services also include Newly Recommended Vaccines as follows:

Newly Recommended Immunizations are covered as mandated by Nevada statute or as otherwise approved by HPN and as set forth in the HPN Preventive Services Guidelines and corresponding Immunization Schedule, subject to the HMO Tier I Copayment outlined in the applicable HMO or POS Attachment A, Benefit Schedule. For POS plans, coverage for Newly Recommended Immunizations is only available under HMO Tier I and not available under Tier 2 or Tier 3.

Newly Recommended Immunizations include childhood and adult immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services with appropriate licensing approval by the Food and Drug Administration.

Attachment A, Benefit Schedule

The HMO Tier I Copayment for Newly Recommended Immunizations:

- HPV Immunization - $45 per injection, in addition to the HMO Tier I Preventive Services office visit Copayment.

Nothing in this Endorsement will change the terms of the EOC or Attachment A, Benefit Schedule except as specifically stated above. This Endorsement shall terminate upon termination of the Group Enrollment Agreement and under the same terms and conditions specified therein.

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

Group Evidence Of Coverage

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

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

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

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

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

Table of Contents

The Department of Business and Industry

State of Nevada

Division Of Insurance

Telephone Numbers for Consumers of Healthcare

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

The hours of operation of the Division are:

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

The Division local telephone numbers are:

Carson City (775) 687-4270

Las Vegas (702) 486-4009

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

1-888-872-3234

All questions about Preexisting Condition Limitation and Creditable Coverage should be directed to HPN's Member Services Department:

Address:

Health Plan of Nevada, Inc.

Attn: Member Services Department

P.O. Box 15645

Las Vegas, NV 89114-5645

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

(702) 242-7300

or 1-800-777-1840

SECTION 1. Eligibility, Enrollment and Effective Date

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

1.1 Who Is Eligible

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

A. Be a bona fide employee of the Group; and

B. Meet the following criteria;

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

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

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

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

  The child must be under the limiting age of 19 years, and except in the case of a child for whom a court has ordered coverage, the child must qualify as a Dependent of the Subscriber under the Internal Revenue Code and Regulations.
- Any unmarried child, under the age of 23 (or age 24 if your employer is considered to be a Small Group) who is a full-time student in an accredited educational institution which is eligible for payment of benefits under the Veterans Administration Program, and who is financially dependent on the Subscriber. Proof of full-time student status must be given to HPN each semester.
- Any unmarried child, under the age of 24, who is on a religious mission and who is financially dependent on the Subscriber. The religious organization must give HPN a letter, which states the Dependent is on a religious mission. Proof of the continuation of the religious mission status must be given to HPN at least twice a year.
- Any unmarried 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 a Dependent enrolled under this EOC before reaching the limiting age, and proof of incapacity and dependency must be given to HPN by the Subscriber within thirty-one (31) days of the child reaching the limiting age; or

  (b) The handicap started before the child reached the limiting age, but the Group was enrolled with another health insurance carrier that covered the child as a handicapped Dependent prior to the Group enrolling with HPN.

HPN 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. HPN's determination of eligibility is final.

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

1.2 Who Is Not Eligible

Eligible Dependent does not include:

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

1.3 Changes In Eligibility Status

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

- Reaching the limiting age.
- Ceasing to be a full-time student.
- Ceasing to satisfy the mental or physical handicap requirements.
- Death.
- Divorce.
- Marriage.
- Transfer of residence or work outside HPN's Service Area.
- Any other event which affects a Dependent's eligibility.

If Subscriber fails to give notice which would have resulted in termination of coverage, HPN shall have the right to terminate coverage retroactively and refund any corresponding premium.

1.4 Enrollment

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

1. **Initial Enrollment Period.** An Initial Enrollment Period is the period of time during which an Eligible Employee and Eligible Family Member may enroll under this Plan as shown in the GEA signed by the Group.
2. **Group Open Enrollment Period.** An Open Enrollment Period of at least thirty-one (31) days may be held at least once a year allowing Eligible Employees and Eligible Family Members to enroll under this Plan without giving evidence of good health.
3. **Special Enrollment Period.** A Special Enrollment Period allows a Special Enrollee to enroll for coverage under this Plan upon a Special Enrollment Event as defined herein during a period of at least thirty-one (31) days following the Special Enrollment Event.
4. **Right to Deny Application.** HPN can deny membership to any person who:
   - Violates or has violated any provision of the HPN EOC.
   - Misrepresents and/or fails to disclose a material fact which would affect coverage under this Plan.
   - Fails to follow HPN rules.
   - Fails to make a premium payment.
5. **Right to Deny Application for Renewal.** As a condition of Group's renewal under this Plan, HPN may require Group to exclude a Subscriber and/or Dependent who committed fraud upon HPN or misrepresented and/or failed to disclose a material fact which affected his coverage under this Plan.

1.5 Effective Date of Coverage

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

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

1. If a person applies to be a Member within thirty-one (31) days of the date he is first eligible to apply, coverage starts on the first

day of the calendar month following the month when the Enrollment Form is received by HPN.

2. Subscriber's newborn natural child is covered for the first thirty-one (31) days from birth. Coverage continues after thirty-one (31) days only if the Subscriber enrolls the child as a Dependent and pays the premium within thirty-one (31) days of the date of birth.
3. An adopted child is covered for the first thirty-one (31) days from birth only if the adoption has been legally completed before the child's birth. A child Placed for Adoption at any other age is covered for the first thirty-one (31) days after the Placement for Adoption.

   Coverage continues after the applicable thirty-one (31) day period only if the Subscriber enrolls the child as a Dependent and pays any premium within thirty-one (31) days following the placement of the child in the Subscriber's home. In the event adoption proceedings are terminated, coverage of a child Placed for Adoption ends on the date the adoption proceedings are terminated.
4. If a court has ordered Subscriber to cover his or her legal spouse or unmarried minor child, that person will be covered for the first thirty-one (31) days following the date of the court order. Coverage continues after thirty-one (31) days if the Subscriber enrolls the Dependent and pays any Dependent's premium. A copy of the court order must be given to HPN.
5. For a Special Enrollee, the Effective Date of Coverage is on the first day of the calendar month after an Enrollment Form is received, unless otherwise specified in the GEA.
6. When a person applies to become a Member during the Open Enrollment Period, coverage starts on the first day of the calendar month following the Open Enrollment Period.

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

   Subscriber must give HPN a copy of the certified marriage certificate, proof of student status or any other required documents before coverage can be effective for other Eligible Family Members.

SECTION 2. Termination

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

2.1 Termination by HPN

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

- Failure to maintain eligibility requirements as set forth in Section 1.
- On the first day of the month that a contribution was due and not received by HPN.
- With thirty (30) days written notice, if the Member allows his or any other Member's HPN ID Card to be used by any other person, or uses another person's HPN ID Card. The Member will be liable to HPN for all costs incurred as a result of the misuse of the HPN ID Card.
- If information given to HPN by the Member in his Enrollment Form or Medical Questionnaire is untrue, inaccurate, or incomplete, HPN has the right to declare the coverage under this Plan null and void as of the original Effective Date of coverage and refund any applicable premium.
- In the case of a Small Group Member, when information provided to HPN by a Small Group Member in his Enrollment Form or Medical Questionnaire is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage, HPN shall have the right to retroactively increase past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had not been provided. If the revised premium rate is not received by

HPN within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to-date.

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

  1. Nonpayment of premiums.
  2. Failure to meet minimum enrollment requirements.
  3. HPN amends this EOC and the Group does not accept the amendment.

2.2 Termination by the Subscriber

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

2.3 Reinstatement

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

2.4 Retroactive Termination

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

2.5 Effect of Termination

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

SECTION 3. Continuation of Coverage

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

3.1 COBRA

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

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

(a) A Subscriber and any enrolled Dependent who would lose coverage under this Plan because of: 1) a reduction in the Subscriber's

regularly scheduled work hours, or 2) because of termination of the Subscriber's employment with the Group for any reason, other than gross misconduct, has the right to elect COBRA continuation coverage. Such coverage may continue for up to eighteen (18) months.

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

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

(b) A Dependent who would lose coverage under this Plan due to any of the qualifying events shown below has the right to elect COBRA continuation coverage. Such coverage may continue for up to thirty-six (36) months.

1. The Subscriber's death.
2. The Subscriber's divorce or legal separation.
3. The Subscriber becomes entitled to Medicare benefits under Part A, Part B, or both.
4. A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

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

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

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

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

For purposes of COBRA continuation coverage, "similarly situated employees" means the group of covered employees, spouses of covered employees, or Dependent children of covered employees receiving coverage under a Group Health Benefit Plan maintained by the employer. Similarly situated employees receive healthcare coverage for a reason other than under COBRA continuation coverage and who, based on all of the facts and circumstances are most similarly situated to the circumstances of the qualified Subscriber immediately before the qualifying event.

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

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

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

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

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

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

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

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

2. **Second Qualifying Event Extension.** If a second qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, an enrolled spouse and Dependent children can qualify for eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan.

   This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Subscriber or former Subscriber:

   - dies;
   - becomes entitled to Medicare benefits (under Part A, Part B, or both);
   - gets divorced or legally separated; or
   - if the Dependent child no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

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

1. the date on which the relevant qualifying event occurs;

2. the date on which there is a loss of coverage under the Plan as a result of the qualifying event; or

3. the date on which the Subscriber or Dependent is informed through the Plan's EOC or the general COBRA notice of their obligation to provide notice and the procedures for providing such notice.

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

- A Subscriber's divorce.
- A Subscriber's legal separation.
- A Dependent no longer meets HPN's eligibility rules.
- A second qualifying event after a Subscriber or Dependent has become entitled to COBRA continuation coverage with a maximum duration of eighteen (18) or twenty-nine (29) months.
- A Subscriber or Dependent entitled to receive COBRA continuation coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration under Title II or XVI of SSA to be disabled at any time during the first sixty (60) days of COBRA continuation coverage.

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

  1) The date of Social Security Administration determination;

  2) The date on which the qualifying event occurs;

  3) The date on which the Subscriber or Dependent loses coverage under the Plan as a result of a qualifying event;

  4) The date on which the Subscriber or Dependent is informed through the Plan's EOC or the general COBRA notice of their obligation to provide notice.

- A disabled Subscriber or Dependent, who has subsequently been determined by the Social Security Administration under Title II or XVI of the SSA to no longer be disabled.

  If a Member is determined by the Social Security Administration to no longer be disabled, the Member must notify the Plan of that fact within thirty (30) days after the Social Security Administration's determination.

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

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

- The GEA is terminated in its entirety.
- The Subscriber, spouse or Dependent fails to pay premiums in full when due.

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

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

- The Subscriber or Dependent becomes eligible for coverage under another Group Health Benefit Plan which does not include a Preexisting Condition clause that applies to the Subscriber or a Dependent.
- The divorced spouse remarries and becomes eligible for coverage under another Group Health Benefit Plan.
- The Subscriber or Dependent becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA continuation coverage.
- A disabled Subscriber is found to be no longer disabled.

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

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

(h) **Plan Contact Information.** For additional information about the Plan or your rights under COBRA continuation coverage, contact HPN's Member Services Department by calling (702) 242-7300 or 1-800-777-1840.

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

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

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

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

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

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

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

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

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

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

a. If the Subscriber served in the uniformed services and is absent from work for less than thirty-one (31) days;

(1) COBRA continuation coverage ends on the day after the date the Subscriber submits an application for reemployment which must not be later than the beginning of the first full regularly scheduled work period on the first full calendar day following completion of the period of service and the expiration of eight (8) hours after a period allowing for the Subscriber's transportation from the place of that service to the Subscriber's residence; or

(2) as soon as possible after the expiration of the eight (8) hour period referred to in (1) if reporting within the period under (1) is impossible or unreasonable through no fault of the Subscriber.

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

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

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

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

3.3 State of Nevada Continuation of Coverage

For Groups who have nineteen (19) or less Eligible Employees:

(a) **Subscriber.** Each terminated Subscriber covered under the Group Plan for at least twelve (12) consecutive months has the right to elect continued medical-only coverage under the Group Plan for eighteen (18) months after termination of employment, if termination is due to reasons other than for gross misconduct or if there is a reduction in the Subscriber's regularly scheduled hours of employment provided the Subscriber continues to reside or work within the HPN Service Area.

However, a Subscriber who voluntarily leaves his employment, or the Dependents of that Subscriber, are not eligible to continue coverage under this provision.

(b) **Eligible Family Members.** The Subscriber's Dependents who continue to reside within HPN's Service Area who have been continuously covered under the Group Plan for at least twelve (12) consecutive months, except as provided in 3.3(g) below, have the

right to elect to continue medical-only coverage under the Group Plan for thirty-six (36) months if they lose coverage due to any of the following reasons:

- The death of the Subscriber.
- Divorce or legal separation of the covered Subscriber.
- A Subscriber selecting Medicare as the primary carrier.
- A Dependent no longer qualifies as a Dependent child as provided in Section 1. of this EOC.

The Dependent of a Subscriber who voluntarily leaves employment with the Group is not eligible for coverage under this provision.

(c) **Required Notification of Election of Continuation of Coverage.** A Subscriber or Dependent identified in (a) or (b) above must notify Group that he is eligible to continue coverage within sixty (60) days of the event which qualifies that person for continued coverage in order to be eligible for continuation of health coverage under this provision.

(d) **Notice from Group.** Upon receiving notice of the qualifying event, the Group will provide the Subscriber or Dependent, information concerning the actions required to elect continuation of coverage and the premium to be paid.

HPN assumes no responsibility for Group's failure to provide such notification to the eligible Members. If HPN is not informed of the election of continuation of coverage within such sixty (60)-day period, HPN assumes no further obligation to provide such continuation of coverage.

(e) **Premium Payment.** The premium for the continued coverage shall be 125% of the premium that would have been payable by Group and must be paid on a quarterly basis. Within sixty (60) days after receipt of the notice from Group described in (d) above, the Subscriber or Dependent must pay the first quarterly premium payment to HPN.

(f) **Required Notification to Member.** Within sixty (60) days after receipt of the notice from the Group described in paragraph (d) above, the Subscriber, spouse, or Dependent child must pay the first quarterly premium payment to HPN.

(g) **Non-eligibility and Termination.** In addition to HPN's other rights to terminate this coverage as set forth in Section 2., continuation of coverage will not be allowed or shall be terminated prior to the end of the eighteen (18)-month or thirty-six (36)-month period, if any of the following occurs:

- The GEA is terminated in its entirety.
- The premium for the continuation of coverage is not paid within thirty (30) days after the due date.
- The Subscriber or Dependent obtains coverage under another Group Health Benefit Plan.
- The Subscriber no longer resides or works within HPN's Service Area or a Dependent no longer resides within HPN's Service Area.
- The Subscriber or spouse qualifies for Medicare.
- The spouse remarries and becomes eligible for coverage under the new spouse's Group Health Benefit Plan.

3.4 Total Disability of Subscriber

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

- The date Subscriber's employment is terminated.
- The date Subscriber obtains other healthcare coverage on an insured or self-insured basis.

- The date the GEA is terminated.
- After a period of twelve (12) months during which benefits for such coverage are provided to the Subscriber.
- The date the Subscriber no longer resides or works within the HPN Service Area or a Dependent no longer resides within the HPN Service Area.

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

3.5 Conversion Rights

For Groups of any size, the Subscriber and/or Dependents shall have the right of conversion when continuation coverage ends, subject to the conversion provisions set forth in this EOC. The benefits provided by the conversion coverage may not be as comprehensive as those provided by this Plan.

3.6 Non-Election

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

3.7 State Law

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

SECTION 4. Conversion Provision

This section tells you under what conditions your coverage can be converted to a non-Group plan.

4.1 Who Can Convert

Only a Subscriber (and his Dependents) terminating Group coverage, and only a Member who no longer meets the eligibility requirements of Section 1., who has been enrolled under this Plan for at least three (3) consecutive months, has the right to convert coverage to the non-Group healthcare program available at the time of application, without giving evidence of good health. The benefits provided by the conversion coverage will be a plan approved by the State of Nevada Division of Insurance and may differ from those offered by this Plan.

4.2 Who Cannot Convert

A Member is not eligible to convert if any of the following occur:

- The GEA is terminated in its entirety or the Member's insured class is terminated.
- The Group replaced this Plan with another fully-insured or self-insured healthcare program within thirty-one (31) days after termination of the GEA.
- The Member does not remain a resident of HPN's Service Area.
- Adoption proceedings are terminated with respect to a child who has been Placed for Adoption with Member.

4.3 Conditions

A Member must apply for conversion and must make timely payment of any applicable premiums within thirty-one (31) days of the date on which he is no longer eligible for Group coverage. The benefits provided by the Individual Conversion Plan may not be as comprehensive as those provided by this Plan.

Conversion rights are subject to all terms and conditions HPN may have in effect at the time of application for conversion. HPN or Group will provide, upon request, further details of the conversion policy.

SECTION 5. Managed Care Program

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

5.1 Managed Care Program

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

5.2 Managed Care Program Requirements

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

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

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

5.3 Managed Care Process

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

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

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

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

5.4 Services Requiring Prior Authorization

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

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility or Hospice.

- Outpatient surgery provided in any setting, including technical and professional services.
- Diagnostic and Therapeutic Services.
- Home Healthcare Services.
- Mental Health, Severe Mental Illness, and Substance Abuse Services.
- All Specialist visits or consultations.
- Prosthetic Devices, Orthotic Devices and Durable Medical Equipment.
- Courses of treatment, including allergy testing or treatment (e.g., skin, RAST); angioplasty; Home Healthcare Services; physiotherapy or Manual Manipulation; and rehabilitation therapy (physical, speech, occupational).

5.5 Emergency Admission Notification

The Member must report all emergency admissions to the Member Services Department within 24 hours of admission or as soon as reasonably possible to authorize continued care at (702) 242-7300 or 1-800-777-1840.

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

5.6 Independent Medical Review; Appeals Rights

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

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

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

5.7 Appeals Rights

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

SECTION 6. 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 8. and Section 9. respectively) prior to obtaining any healthcare services.

6.1 Availability of Covered Services

Members are entitled to receive the Covered Services set forth in Section 7 herein and the Attachment A Benefit Schedule subject to all terms and conditions of this EOC, and payment of required premium. These Covered Services are available only if and to the extent that they are:

(a) Provided, prescribed or arranged by the Member's PCP;

(b) Specifically authorized through HPN's Managed Care Program;

(c) Received in HPN's Service Area through a Plan Provider; and

(d) Medically Necessary as defined in this EOC.

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

6.2 Agreement of Member

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

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

6.3 Continuity of Care from Plan Providers

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

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

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

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

Address:

Health Plan of Nevada, Inc.

Attn: Provider Services Dept.

P.O. Box 15645

Las Vegas, NV 89114-5645

Phone:

(702) 242-7300

1-800-777-1840

SECTION 7. Covered Services

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

7.1 Healthcare Facility Services

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

Accommodations:

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

Services and Supplies. Covered Services and supplies provided by a Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility 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.

7.2 Medical – Physician Services

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

- direct physical examination of the patient;
- examination of some aspect of the patient by means of pathology laboratory or electronic monitoring procedure which is a generally recognized and accepted procedure for diagnostic or therapeutic purposes in the treatment of an Illness or Injury;

- procedures for prescribing or administering medical treatment;
- Manual Manipulation (except for reductions of fractures or dislocations);
- treatment of the temporomandibular joint including Medically Necessary dental procedures, such as dental splints, subject to the maximum benefit limitation;
- anesthesia services;
- family planning services including sterilization procedures; and
- limited diagnostic and therapeutic infertility services determined to be Medically Necessary and Prior Authorized by HPN's Managed Care Program. Covered Services do not include those services specifically excluded herein, but do include limited:
  - Laboratory studies;
  - Diagnostic procedures; and
  - Artificial insemination services, up to six (6) cycles per Member per lifetime.

7.3 Medical – Physician Consultations

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

7.4 Preventive Healthcare Services

Covered Services include the following Preventive Healthcare Services in accordance with the recommended schedule outlined in the HPN Preventive Guidelines included in your member kit:

- hearing and vision screening performed by the PCP to determine the need for hearing correction or eye refractions for children;
- well child care for a healthy Dependent infant or child, office visits for the purpose of exams to assess the child's state of health, routine lab tests during these visits and childhood immunizations;
- routine physical exams;
- annual prostate exam for nonsymptomatic men;
- annual colorectal cancer exam;
- an annual cytologic screening test for women 18 years of age or older; and
- one (1) baseline mammogram for women 35 years of age or older, an annual mammogram for women 40 years of age or older.

7.5 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.

7.6 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.

7.7 Organ and Tissue Transplant Surgical Services

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

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

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

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

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

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

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

7.8 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.

7.9 Emergency Services

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

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

- Sore throats.
- Flu or fever.
- Earaches.
- Sore or stiff muscles.
- Sprains, strains or minor cuts.

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

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

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

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

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

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

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

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

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

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

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

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

7.10 Ambulance Services

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

7.11 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. Prescribed drugs under this provision do not include Self-Injectable Prescription Drugs. Please refer to the optional HPN Prescription Drug Benefit Rider, if applicable to your Plan, for information on benefits available for Self-Injectable covered drugs.
- One (1) medical social service consultation per course of treatment.
- One (1) nutrition consultation by a certified registered dietitian.
- Health aide services furnished to Member only when receiving nursing services or therapy.

7.12 Short-Term Rehabilitation Services – Inpatient and Outpatient

Short-Term Rehabilitation therapy Covered Services include:

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

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

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

7.13 Laboratory Services

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

7.14 Routine Radiological and Non-Radiological Diagnostic Imaging Services

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

7.15 Other Diagnostic and Therapeutic Services

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

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

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

7.16 Prosthetic and Orthotic Devices

Covered Services include the following devices when received in connection with an Illness or Injury occurring after Member's Effective Date under this Plan and authorized by HPN's Managed Care Program:

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

7.17 Durable Medical Equipment

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

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

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

HPN will not be responsible for the following:

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

7.18 Mental Health Services and Severe Mental Illness Services

All benefits for Mental Health and Severe Mental Illness Services are subject to HPN's Managed Care Program through Behavioral Healthcare Options and any applicable benefit maximums shown in the Attachment A Benefit Schedule.

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

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

Severe Mental Illness Services. When authorized by HPN, Covered Services include Inpatient and outpatient treatment for Severe Mental Illness as defined in this EOC. Benefits for the treatment of Severe Mental Illness are subject to the benefit levels and Calendar Year maximum number of days shown in the Attachment A Benefit Schedule.

For the purpose of determining benefits and benefit maximums:

- Outpatient visits for the purpose of medication management will not reduce the maximum number of visits for which benefits for outpatient services are payable.
- Two (2) visits for partial or respite care, or a combination thereof may be substituted for each (1) day of hospitalization not used by the Member.

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

7.19 Substance Abuse Services

All benefits for Inpatient Substance Abuse Services are subject to HPN's Managed Care Program through Behavioral Healthcare Options and the limits listed in the Attachment A Benefit Schedule.

- **Inpatient:** when there has been a history of multiple outpatient treatment failures or when outpatient treatment is not feasible, services for diagnosis and medical treatment for alcoholism and abuse of drugs.
- **Outpatient:** services for the diagnosis, medical treatment and rehabilitation, including individual, group, and family counseling, and outpatient detoxification services for recovery from the effects of alcoholism and abuse of drugs.
- **Detoxification:** treatment for withdrawal from the physiological effects of alcohol and drug abuse. Inpatient detoxification is considered appropriate treatment only for life-threatening withdrawal syndromes associated with drug and alcohol dependence.

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

All admissions for Emergency Services are reviewed Retrospectively to determine if the treatment received was Medically Necessary and appropriate. If the Member is admitted to a Mental Health or Substance Abuse facility for

non-emergency treatment without Prior Authorization, Member will be responsible for the cost of services received.

7.20 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.

Benefits for reconstructive surgery performed within three (3) years following a mastectomy that was covered under this Plan, while the patient is no longer covered by HPN under this Plan, will be paid at the same level as would have been provided at the time of the mastectomy except that no coverage will be provided for any complications relating to the reconstructive surgery.

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 HPN 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 HPN under this Plan.

7.21 Special Food Product / Enteral Formulas

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

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

7.22 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.

7.23 Dental Anesthesia Services

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

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

Coverage for dental anesthesia pursuant to this section is limited to that provided by a Plan 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.

7.24 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/m^2; or
- Have a BMI greater than 35kg/m^2 with significant co-morbidities; and
- Can provide documented evidence that dietary attempts at weight control are ineffective; and
- Must be at least 18 years old.

Documentation supporting the reasonableness and necessity of 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.

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

7.25 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.

7.26 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);
    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 the Member is eligible to participate in the clinical trial or study;
- Any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the Member, if the drug or device is not paid for by the manufacturer, distributor, or Provider;
- Services normally covered under this Plan that are required as a result of the medical treatment or related complications provided in the clinical trial or study when not provided by the sponsor of the clinical trial or study;
- Services required for the clinically appropriate monitoring of the Member during the clinical trial or study when not provided by the sponsor of the clinical trial or study.

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

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 HPN's rate of reimbursement as payment in full.

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

7.27 Medical Supplies

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

- Catheter and catheter supplies – Foley catheters, drainage bags, irrigation trays;
- Colostomy bags (and other ostomy supplies);

- Dressing/wound care-sterile dressings, ace bandages, sterile gauze and toppers, Kling and Kerlix rolls, Telfa pads, eye pads, incontinent pads, lambs wool pads, sterile solutions, ointments, sterile applicators, sterile gloves;
- Elastic stockings;
- Enemas and douches;
- IV supplies;
- Sheets and bags;
- Splints and slings;
- Surgical face masks; and
- Syringes and needles.

7.28 Post-Cataract Surgical Services

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

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

SECTION 8. Exclusions

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

8.1 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.

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

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

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

8.5 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.

8.6 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.

8.7 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 HPN to relate to a dental condition.

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

8.8 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.

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

- 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.

8.10 Reversal of surgically performed sterilization or subsequent resterilization.

8.11 Elective abortions.

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

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

8.14 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.

8.15 Venipuncture (drawing of blood for laboratory tests).

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

8.17 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.

8.18 Treatment of:

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

For purposes of this Exclusion,

- "chronic" means any condition existing for more than six (6) months.
- Counseling and other forms of cognitive and behavioral therapy is excluded in connection with the treatment of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD). This section is not meant to exclude an evaluation for a diagnosis of ADD or ADHD, or to exclude any corresponding outpatient prescription drugs (if otherwise available under the outpatient Prescription Drug Benefit Rider if applicable to your Plan) when prescribed by a treating Plan Provider, nor is this meant to exclude an evaluation for the diagnosis of any other co-morbid issues.

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

8.20 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.

8.21 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.

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

8.23 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.

8.24 Pain management invasive procedures as defined by HPN's protocols for chronic, intractable pain unless Prior Authorized by HPN and provided by a Plan Provider who is a pain management Specialist. Any Prior Authorized pain management procedures

will be subject to the applicable facility and professional Copayments and/or Coinsurance amount as set forth in Attachment A, Benefit Schedule.

8.25 Acupuncture or hypnosis.

8.26 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.

8.27 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.

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

8.29 Outpatient Prescription Drugs, nutritional supplements, vitamins, herbal medicines, appetite suppressants, Self-Injectable and Orphan drugs, and other over-the-counter drugs, except as specifically covered in the outpatient Prescription Drug Benefit Rider, if applicable, to your Plan. This includes drugs and supplies for a patient's use after discharge from a Hospital. Drugs and medicines approved by the FDA for experimental or investigational use or any drug that has been approved by the FDA for less than nine (9) months unless Prior Authorized by HPN.

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

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

8.32 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.

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

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

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

8.36 Experimental or investigational treatment or devices as determined by HPN.

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

8.38 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.

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

8.40 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.

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

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

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

8.44 Autologous blood donations.

8.45 Healthcare services or supplies required as a result of an attempt to commit, or committing a felony by the Member.

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

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

SECTION 9. Limitations

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

9.1 Liability

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

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

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

9.2 Calendar Year and Lifetime Maximum Benefit Limitations

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

9.3 Reimbursement

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

SECTION 10. Coordination of Benefits (COB)

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

10.1 The Purpose of COB

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

10.2 Benefits Subject to COB

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

10.3 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.4 When COB Applies

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

10.5 Determination Rules

The rules establishing the order of benefit determination are:

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

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

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

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

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

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

1. If there is a court decree that would establish financial responsibility for the medical, dental or other healthcare expenses with respect to the child, the benefits of a Plan that covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan that covers the child as a Dependent child;

2. Second, the Plan of the parent with custody of the child;

3. Third, the Plan of the spouse (stepparent) of the parent with custody of the child;

4. Finally, the Plan of the parent not having custody of the child.

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

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

Two consecutive Plans shall be treated as one Plan if:

1. That person was eligible under the second Plan within 24 hours after the termination of the first Plan; and

2. There was a change in the amount or scope of a Plan's benefits or there was a change in the entity paying, providing or administering Plan benefits; or

3. There was a change from one type of Plan to another (e.g., single employer to multiple employer Plan).

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

10.6 How COB Works

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

10.7 Right to Receive and Release Information

In order to decide if this COB Section (or any other Plan's COB Section) applies to a claim, HPN (without the consent of or notice to any person) has the right to the following:

a) Release to any person, insurance company or organization, the necessary claim information.

b) Receive from any person, insurance company or organization, the necessary claim information.

c) Require any person claiming benefits under this Plan to give HPN any information needed by HPN to coordinate those benefits.

10.8 Facility of Payment

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

10.9 Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy HPN's obligation under this section, HPN has the right to recover the excess amount from one or more of the following:

a) Any persons to or for whom such payments were made.

b) Any group insurance companies or service plans.

c) Any other organizations.

10.10 Failure to Cooperate

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

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

SECTION 11. Subrogation

If a Member's Illness or Injury is caused by a third party, and the Member has the right to recover damages from that third party, HPN will provide or make payment for Covered Services related to

such Illness or Injury. Acceptance of such Covered Services or payment shall constitute consent to the provisions of this section.

11.1 Member Reimbursement Obligation

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

11.2 HPN's Right of Recovery

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

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

11.3 Member Cooperation

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

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

11.4 Exclusion of Make-Whole Doctrine

The make-whole doctrine shall not apply to the rights of HPN under this section.

SECTION 12. General Provisions

12.1 Relationship of Parties

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

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

12.3 Contestability

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

12.4 Authority to Change the Form or Content of this Plan

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

12.5 Identification Card

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

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

12.6 Notice

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

Health Plan of Nevada, Inc.

P.O. Box 15645

Las Vegas, Nevada 89114-5645

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

12.7 Interpretation of the EOC

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

12.8 Assignment

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

12.9 Modifications

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

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

12.10 Clerical Error

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

12.11 Policies and Procedures

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

12.12 Overpayments

HPN 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 HPN. HPN has the right to offset any such overpayment against any future payments.

12.13 Cost Containment Features

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

a) Preventive healthcare benefits.

b) The Managed Care Program.

c) Benefit limitations on certain services.

d) Member Copayments.

12.14 Release of Records

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

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

12.15 Reimbursement for Claims

Non-Plan Providers may require immediate payment for their services and supplies. When seeking reimbursement from HPN for expenses incurred in connection with services received from Non-Plan Providers, the Member must complete a Non-Plan Provider Claim Form and submit it to the HPN Claims Department with copies of all of the medical records, bills and/or receipts from the Provider. Non-Plan Provider Claim Forms can be obtained by contacting the Member Services Department at (702) 242-7300 or 1-800-777-1840.

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

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

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

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

12.16 Timely Filing Requirement

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

No payments shall be made under this Plan with respect to any claim, including additions or corrections to a claim which has already been submitted, that is not received by HPN within twelve (12) months after the date Covered

Services were provided. In no event will HPN pay more than HPN's Eligible Medical Expense for such services.

12.17 Gender References

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

12.18 Legal Proceedings

No action of law or equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of claim has been filed 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.

12.19 Availability of Providers

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

12.20 Physician Incentive Plan Disclosure

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

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

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

12.21 Provisions Deemed to be in Compliance for National Accounts

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

12.22 Authorized Representative

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

Health Plan of Nevada, Inc.

Attn:

Customer Response and Resolution Dept.

P.O. Box 15645

Las Vegas, NV 89114-5645

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

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

12.23 Failure to Obtain Prior Authorization

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

12.24 Timing of Notification of Benefit Determination

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

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

12.25 Notification of an Adverse Benefit Determination

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

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

- If the Adverse Benefit Determination is based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge.

SECTION 13. Appeals Procedures

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

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

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

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

The following Appeals Procedures will be followed if the medical service site matter cannot be resolved at the site or if the concern involves the Adverse Benefit Determination of a Claim for Benefits.

- **Informal Review:** An Adverse Benefit Determination or medical site service complaint/concern which is directed to the HPN Member Services Department via phone or in person. If an Informal Review is resolved to the satisfaction of the Member, the matter ends. The Informal Review is **voluntary**.
- **1st Level Formal Appeal:** An appeal of an Adverse Benefit Determination filed either orally or in writing which HPN's Customer Response and Resolution Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the Member, the appeal is closed. The 1st Level Formal Appeal is **mandatory** if the Member is not satisfied with the initial determination and the Member wishes to appeal such determination.
- **2nd Level Formal Appeal:** If a 1st Level Formal Appeal is not resolved to the Member's satisfaction, a Member may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted in writing and reviewed by the Grievance Review Committee. The 2nd Level Formal Appeal is **voluntary** for all Adverse Benefit Determinations.
- **Grievance Review Committee:** A committee of three (3) or more individuals, the majority of which must be Members of HPN, chaired by the Assistant Vice President of HPN's Member Services, or his or her designee, and comprised of such other individuals as the chairperson deems appropriate.
- **Member Services Representative:** An employee of HPN that is assigned to assist the Member or the Member's Authorized Representative in filing a grievance with HPN or appealing an Adverse Benefit Determination.

13.1 Informal Review

A Member who has received an Adverse Benefit Determination of a Claim for Benefits may request an Informal Review. All Informal Reviews must be made to HPN's Member Services Department within sixty (60) days of the Adverse Benefit Determination. Informal Reviews not filed in a timely manner will be deemed waived. The Informal Review is a **voluntary** level of appeal.

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

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

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

13.2 1st Level Formal Appeal

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

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

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

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

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

Health Plan of Nevada, Inc.

Attn: Customer Response and Resolution Department

P.O. Box 15645

Las Vegas, NV 89114-5645

Fax: 1-702-240-6507

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

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

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Claim for Benefits;
- A statement describing any voluntary appeal procedures offered by HPN and the Member's right to receive additional information describing such procedures;
- For Member's whose coverage is subject to ERISA, a statement of the Member's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination, if applicable;

- A statement that any internal rule, guideline, protocol or other similar criteria that was relied on in making the determination is available free of charge upon the Member's request; and
- If the Adverse Benefit Determination is based on Medical Necessity or experimental 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.

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

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

13.3 Expedited Appeal

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

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

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

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

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

13.4 2nd Level Formal Appeal

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

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

The Member shall be entitled to the same reasonable access to copies of documents referenced above under the 1st Level Formal Appeal.

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

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

Upon HPN's receipt of the written request, the request will be forwarded to the Grievance Review Committee along with all available documentation relating to the appeal.

The Grievance Review Committee shall:

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

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

- The specific reason or reasons for upholding the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the benefit determination is based; and
- A statement describing any additional voluntary levels of appeal.

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

13.5 HPN Board of Directors Hearing

If the Member does not accept the written decision of the Grievance Review Committee under Section 13.4 herein, the Member may submit a written request for hearing before the HPN Board of Directors. The HPN Board of Directors hearing is a **voluntary** level of appeal. This request must be received by HPN within ten (10) days following the Member's receipt of the Grievance Review Committee's written decision of the 2ndLevel Formal Appeal. HPN's Board of Directors meets once each calendar quarter. The Member will be informed of the Board decision within ten (10) days after the date the quarterly meeting is held.

13.6 Arbitration of Disputes of an Independent Medical Review

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

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

13.7 External Review

HPN offers Members the right to an External Review of a final Adverse Benefit Determination when a Member or the Member's Physician receives notice of a final Adverse Benefit Determination from HPN's Managed Care Program, and when the Member is required to pay $500 or more for healthcare services that are the subject of the final Adverse Benefit Determination. The Member is entitled to an External Review only after the Member has exhausted all procedures provided in this Plan for reviewing the Adverse

Benefit Determination or if HPN agrees in writing to submit the matter to External Review before the Member has exhausted all procedures provided in this Plan for reviewing the Adverse Benefit Determination. The Member, Member's Physician, or an Authorized Representative may within sixty (60) days after receiving notice of such final Adverse Benefit Determination, submit a request to HPN's Managed Care Program for an External Review.

Within five (5) days after HPN receives such a request, HPN shall notify the Member, his Authorized Representative or Physician, and the Nevada Office for Consumer Health Assistance that the request has been received and filed.

The Nevada Office for Consumer Health Assistance shall assign an External Review Organization to review the case.

Within five (5) days after receiving notification specifying the assigned External Review Organization from the Nevada Office for Consumer Health, HPN shall provide to the selected External Review Organization all documents and materials relating to the final Adverse Benefit Determination, including, without limitation:

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

Within five (5) days after the External Review Organization receives the required documentation from HPN, they shall notify the Member, his Physician, and HPN if any additional information is required to conduct the review.

The External Review Organization shall approve, modify, or reverse the final Adverse Benefit Determination within fifteen (15) days after it receives the information required to make such a determination.

The External Review Organization shall submit a copy of its determination, including the basis thereof, to the:

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

If the determination of an External Review Organization concerning an External Review of a final Adverse Benefit Determination is in favor of the Member, the determination is final, conclusive and binding.

The cost of conducting an External Review of a final Adverse Benefit Determination will be paid by HPN.

13.8 Expedited External Review

If the Member's healthcare Provider submits proof to HPN that failure to proceed in an expedited manner may jeopardize the life or health of the Member, then HPN shall approve or deny a request for an expedited External Review of an Adverse Benefit Determination no later than seventy-two (72) hours after the request for an expedited External Review is received.

If HPN approves the expedited External Review, HPN shall assign the request to an External Review Organization no later than one (1) business day after approving the request. All relevant medical documents previously listed herein that were used to establish the final Adverse Benefit Determination will be forwarded to the External Review Organization concurrently.

The External Review Organization shall complete its External Review no later than two (2) business days after initially being assigned the case unless the Member and HPN agree to a longer time period.

The External Review Organization shall notify the following parties by telephone no later than one (1) business day after completing its External Review:

- Member;
- Member's Physician;

- Authorized Representative of the Member, if any; and
- HPN.

The External Review Organization shall then submit a written copy of its determination no later than five (5) business days to the applicable parties listed above.

If the determination of an External Review Organization concerning an External Review of a final Adverse Benefit Determination is in favor of the Member, the determination is final, conclusive and binding.

The cost of conducting an External Review of a final Adverse Benefit Determination will be paid by HPN.

13.9 Office for Consumer Health Assistance

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

SECTION 14. Glossary

14.1 "Adverse Benefit Determination" means a decision by the Plan to deny, in whole or in part, a Member's Claim for Benefits. Receipt of an Adverse Benefit Determination entitles the Member or his Authorized Representative to appeal the decision, utilizing HPN's Appeals Procedures.

The External Review provision in this EOC only applies if the Adverse Benefit Determination was made based on the Plan's determination that the denied service or supply was not Medically Necessary or that the denied service or supply was determined to be experimental or investigational. 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.

14.2 "Ambulance" means a vehicle licensed to provide Ambulance services.

14.3 "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.

14.4 "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 a final Adverse Benefit Determination. The designation must be in writing unless the claim or appeal involves an Urgent Care Claim and a healthcare professional with knowledge of the Member's medical condition is seeking to act on the Member's behalf as his Authorized Representative.

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

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

14.7 "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).

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

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

14.10 "Copayment" means the amount the Member pays when a Covered Service is received.

14.11 "Copayment Maximum" means the maximum amount of Copayments a Member is required to pay for Covered Services in a Calendar Year in order for full benefits to be payable for Covered Services obtained after the Calendar Year Copayment Maximum is met. For the remainder of the Calendar Year, no further Copayments are required. The Calendar Year Copayment Maximum does not include charges for services that are not Covered Services, services that are not Prior Authorized through HPN's Managed Care Program, or charges in excess of the stated Covered Service benefit maximums as set forth in Attachment A Benefit Schedule.

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

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

14.14 "Creditable Coverage" means certain types of coverage defined by law which are credited against and reduce the length of any applicable Preexisting Condition limitation period. Creditable Coverage includes coverage under any Health Benefit Plan including individual and group plans, including coverage offered through Medicaid, Medicare, the uniformed services, state health benefits risk pool, State Children's Health Insurance Program, the Indian Health Service or tribal organization, Federal Employees Health Benefits Program, a public health plan, or the Peace Corps. Coverage prior to a Significant Break in Coverage is not credited toward any Preexisting Condition limitation period.

14.15 "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.

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

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

14.17 "Durable Medical Equipment" or "DME" means medical equipment that:

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

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

14.19 "Eligible Employee" means a natural person that:

A. Is a bona fide employee of the Group; and

B. Meets the following criteria:

- Is employed full-time;

- Is actively at work;
- Works at least the minimum number of hours per week indicated by the Group in the Attachment A to the GEA (typically 30 hours);
- Meets the applicable waiting period indicated by the Group in the Attachment A to the GEA;
- Enrolls during an enrollment period;
- Lives or work in HPN's Service Area; and
- Works for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in the Attachment A to the GEA.

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

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

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

14.22 "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.

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

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

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

14.26 "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.

14.27 "External Review" means an independent review of an Adverse Benefit Determination conducted by an External Review Organization.

14.28 "External Review Organization" means an organization that:

- Conducts an External Review of a final Adverse Benefit Determination; and
- Is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

14.29 "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.

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

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

14.32 "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.

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

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

14.35 "HPN Reimbursement Schedule" means the schedule showing the amount HPN will pay for Eligible Medical 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 HPN determines to be similar in complexity and nature with reference to other industry and governmental sources.

14.36 "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.

14.37 "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.

14.38 "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.

14.39 "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.

14.40 "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.

14.41 "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.

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

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

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

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

14.46 "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.

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

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

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

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

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

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

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

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

14.50 "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.

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

14.52 "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.

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

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

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

14.56 "Orphan Drugs" means a prescription drug for the treatment or prevention of a rare disease or condition as determined by the FDA. A rare disease is one that affects less than 200,000 people but for which there is no reasonable expectation that the cost of developing the drug and making it available will be recovered from sales of that drug in the U.S.

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

14.58 "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.

14.59 "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.

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

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

14.62 "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.

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

14.64 "Preexisiting Condition" means any Illness, Injury, or any related condition to an Illness or Injury, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the Enrollment Date of coverage under this Plan. This term does not include genetic information in the absence of a diagnosis of the condition related to such information nor does it include pregnancy, Complications of Pregnancy, coverage for enteral formulas and special food products, newborns, and newly adopted children. Preexisting Condition does not apply to HPN's Group HMO or Point-of-Service Plans.

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

14.66 "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.

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

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

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

14.70 "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.

14.71 "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.

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

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

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

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

14.76 "Self-Injectable" means an injectable drug which is to be administered subcutaneously or intramuscularly, that does not require administration by a licensed Practitioner. Injectable drugs meeting this definition are considered Self-Injectable even when administered by a licensed Practitioner or someone other than the Member.

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

14.78 "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.

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

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

14.81 "Significant Break in Coverage" means a period of sixty-three (63) or more consecutive days during each of which the Member does not have any Creditable Coverage. Certain days are not included in determining whether there is a Significant Break in Coverage including days in a Waiting Period or periods of FMLA leave during which the Member does not have Creditable Coverage. The sixty-three (63) day period shall not begin until a Certificate of Creditable Coverage is provided to the Member; provided, however, that such period will not be delayed beyond forty-four (44) days after a Member's Creditable Coverage ends.

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

14.83 "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.

14.84 "Small Group" means an employer who employed an average of at least two (2) employees, but not more than fifty (50) employees who have a normal workweek of thirty (30) hours or more and who employs at least two (2) employees on the first day of the Plan year.

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

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

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

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

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

14.87 "Special Enrollment Period" means the thirty-one (31)-day period following a Special Enrollment Event (or, if later, following the date on which a Certificate of Creditable Coverage is provided but in no event beginning later than forty-four (44) days from the date of the Special Event) during which an Eligible Employee and/or any Eligible Family Members can enroll under this Plan as follows:

1. the Eligible Employee (and/or any Eligible Family Members) had coverage under any Health Benefit Plan; and

2. a Special Enrollment Event has occurred.

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

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

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

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

14.92 "Totally Disabled" means:

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

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

a) the date 365 days after the date of the transplant; or

b) the date when the Member is no longer covered under this Plan, whichever is earlier.

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

14.95 "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.

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

14.97 "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.

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

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Attachment B
Service Area Description

To enroll in Health Plan of Nevada, you must reside or work in one of the following areas, or reside or work within twenty-five miles of a contracted provider:

Clark County (all zip codes):

- Blue Diamond
- Boulder City
- Bunkerville
- Cottonwood Cove
- Glendale
- Goodsprings
- Green Valley
- Henderson
- Indian Springs
- Jean
- Las Vegas
- Laughlin
- Logandale
- Mesquite
- Moapa
- Mt. Charleston
- Nellis AFB
- Nelson
- North Las Vegas
- Overton
- Pittman
- Searchlight
- Stateline

Esmeralda County (all zip codes):

- Dyer
- Fish Lake Valley
- Goldfield
- Silver Peak

Lyon County (all zip codes):

- Dayton
- Fernley
- Silver City
- Silver Springs
- Smith
- Wellington
- Yerington

Mineral County (all zip codes):

- Babbit
- Hawthorne
- Luning
- Mina
- Schurz

Nye County (all zip codes):

- Amargosa Valley
- Beatty
- Gabbs
- Manhattan
- Mercury
- Pahrump
- Round Mountain
- Tonopah

Service Area

Washoe County (designated zip codes only):	
Sparks	89431, 89432 89433, 89434 89435, 89436
Wadsworth	89442
Reno	89501, 89502 89503, 89504 89505, 89506 89507, 89509 89510, 89511 89512, 89513 89515, 89520 89521, 89523 89533, 89570 89557, 89595 89599

Basic and Supplemental Health Services for Health Plan of Nevada, Inc.'s Service Areas commenced in August 1982.

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HPN HMO C15 Medical Plan

Attachment A Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Medical – Physician Services and Physician Consultations		
• Office Visit/Consultation Primary Care Physician	No	$15 per visit
Specialist	Yes	$30 per visit
• Inpatient Visit/Consultation Primary Care Physician	Yes	No charge
Specialist	Yes	No charge
Preventive Healthcare Services	No	$15 per visit
Laboratory Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent laboratory.*	Yes	$15 per visit
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent radiological facility.*	Yes	$15 per visit
Emergency Services *Within* the Service Area		
• Urgent Care Facility	No	$20 per visit

Legal Documents

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Emergency Services *Within* the Service Area (continued)		
• Physician's Services in Emergency Room	No	$25 per visit
• Emergency Room Facility	No	$50 per visit; waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	$300 per admission
• Office Visit to Non-Plan Physician	No	$25 per visit
Emergency Services *Outside* the Service Area		
• Urgent Care Facility	No	$40 per visit
• Physician's Services in Emergency Room	No	$50 per visit
• Emergency Room Facility	No	$75 per visit; waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	$300 per admission
• Office Visit	No	$30 per visit
Ambulance Services		
• Emergency – Ground Transport	No	$50 per trip
• Emergency – Air Transport	No	50% of EME per trip
• Non-Emergency – HPN Arranged Transfers	Yes	No charge
Inpatient Hospital Facility Services *Elective and Emergency Post-Stabilization Admissions*	Yes	$300 per admission
Outpatient Hospital Facility and Ambulatory Surgical Facility Services	Yes	$50 per admission

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Physician Surgical Services – Inpatient and Outpatient		
• Inpatient Hospital Facility	Yes	$50 per surgery
• Outpatient Hospital Facility	Yes	$25 per surgery
• Physician's Office Primary Care Physician (in addition to office visit Copayment)	No	$15 per visit
Specialist (in addition to office visit Copayment)	Yes	$30 per visit
Assistant Surgical Services	Yes	No charge
Anesthesia Services	Yes	$100 per surgery
Gastric Restrictive Surgical Services *The maximum lifetime benefit for all Gastric Restrictive Surgical Services is $5,000 per Member.*		
• Physician Surgical Services	Yes	50% of EME. Subject to maximum benefit.
• Complications *The maximum lifetime benefit for all complications in connection with Gastric Restrictive Surgical Services is $5,000 per Member.*	Yes	50% of EME. Subject to maximum benefit.
Mastectomy Reconstructive Surgical Services		
• Physician Surgical Services	Yes	$50 per surgery
• Prosthetic Device for Mastectomy Reconstruction *Unlimited.*	Yes	$750 per device
Oral Physician Surgical Services		
• Office Visit	Yes	$30 per visit
• Physician Surgical and Diagnostic Services Inpatient Hospital Facility	Yes	$50 per surgery
Outpatient Hospital Facility	Yes	$25 per surgery

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility	Yes	$300 per admission. Subject to maximum benefit.
• Physician Surgical Services – Inpatient Hospital Facility	Yes	$50 per surgery. Subject to maximum benefit.
• Transportation, Lodging and Meals *The maximum benefit per Member per Transplant Benefit Period for transportation, lodging and meals is $10,000. The maximum daily limit for lodging and meals is $200.*	Yes	No charge. Subject to maximum benefit.
• Procurement *The maximum benefit per Member per Transplant Benefit Period for Procurement of the organ/ tissue is $15,000 of EME.*	Yes	No charge. Subject to maximum benefit.
• Retransplantation Services *The maximum benefit for Retransplantation Services is 50% of EME, which does not apply towards the Calendar Year Copayment Maximum.*	Yes	50% of EME. Subject to maximum benefit.
The maximum lifetime benefit that will be paid for a Member for Covered Services received in connection with all Covered Transplant Procedures combined is ***$1,000,000.***		
Post-Cataract Surgical Services		
• Frames and Lenses *Maximum frame allowance of $100.*	Yes	$10 per pair of glasses. Subject to maximum benefit.
• Contact Lenses *Maximum contact lenses allowance of $100.*	Yes	$10 per set of contact lenses. Subject to maximum benefit.
Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Member per surgery.		
Home Healthcare Services (*does not include Self-Injectable Prescription Drugs)* *Refer to your Outpatient Prescription Drug Benefit Rider, if applicable, for your Outpatient Self-Injectable Covered Drug benefit.*		
• Physician House Calls	Yes	$20 per visit

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Home Healthcare Services (continued)		
• Home Care Services	Yes	$20 per visit
• Private Duty Nurse	Yes	No charge
Hospice Care Services		
• Inpatient Hospice Facility	Yes	$300 per admission
• Outpatient Hospice Services	Yes	No charge
• Inpatient Respite Services *Limited to a maximum benefit of $1,500 per Member per Calendar Year.*	Yes	$300 per admission. Subject to maximum benefit.
• Outpatient Respite Services *Limited to a maximum benefit of $1,000 per Member per Calendar Year.*	Yes	$15 per visit. Subject to maximum benefit.
• Bereavement Services *Limited to a maximum benefit of five (5) group therapy sessions or $500, whichever is less. Treatment must be completed within six (6) months of the date of death.*	Yes	$20 per visit. Subject to maximum benefit.
Skilled Nursing Facility *Limited to a maximum benefit of one hundred (100) days per Member per Calendar Year.*	Yes	$300 per admission. Subject to maximum benefit.
Manual Manipulation *Applies to Medical-Physician Services and Chiropractic office visit.*	Yes	$30 per visit
Short-Term Rehabilitation Services		
• Inpatient Hospital Facility	Yes	$300 per admission. Subject to maximum benefit.
• Outpatient *All Inpatient and Outpatient Short-Term Rehabilitation Services are subject to a maximum benefit of sixty (60) days/visits per Member per Calendar Year.*	Yes	$15 per visit. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Durable Medical Equipment *For rental or purchase at HPN's option.*	Yes	$100 or 50% of EME of purchase or rental price, whichever is less.
Genetic Disease Testing Services *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	25% of EME per test
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.*	Yes	$30 per visit
Medical Supplies	Yes	No charge
Other Diagnostic and Therapeutic Services *Copayment is in addition to the Physician office visit Copayment and applies to services rendered in a Physician's office or at an independent facility.*		
• Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.	Yes	$30 per day
• Dialysis	Yes	$30 per day
• Therapeutic Radiology	Yes	$30 per day
• Allergy Testing and Serum Injections	Yes	$30 per visit
• Otologic Evaluations	Yes	$30 per visit
• Other services such as complex diagnostic imaging; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.	Yes	$30 per test or procedure
• Positron Emission Tomography (PET Scan)	Yes	$750 per test

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Prosthetic and Orthotic Devices *Limited to a maximum lifetime benefit of $10,000 per Member including:* • *repairs; and* • *post-mastectomy external prosthetic device.*	Yes	$750 per device. Subject to maximum benefit.
Self-Management and Treatment of Diabetes		
• Education and Training	No	$15 per visit
• Supplies (except for Insulin Pump Supplies)	No	$5 per therapeutic supply
Insulin Pump Supplies	Yes	$10 per therapeutic supply
• Equipment (except for Insulin Pump)	Yes	$20 per device
Insulin Pump	Yes	$100 per device
Special Food Products and Enteral Formulas *Limited to a maximum benefit of $2,500 per Member per Calendar Year for Special Food Products only.*	Yes	No charge. See maximum benefit.
Temporomandibular Joint Treatment *Dental-related treatment is limited to $2,500 per Member per Calendar Year and $4,000 maximum lifetime benefit per Member.*	Yes	50% of EME. Subject to maximum benefit.
Mental Health Services		
• Inpatient Hospital Facility *Limited to a maximum benefit of thirty (30) days per Member per Calendar Year.*	Yes	$300 per admission. Subject to maximum benefit.
• Outpatient Treatment		
Group Therapy *Unlimited visits.*	Yes	$15 per visit
Individual, Family and Partial Care Therapy** *Limited to a maximum benefit of twenty (20) visits per Member per Calendar Year.* *Benefit maximum does not apply to visits for medication management.*	Yes	$20 per visit. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Mental Health Services (continued) *** Partial Care Therapy refers to a coordinated Outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.*		
Severe Mental Illness Services		
• Inpatient Hospital Facility *Limited to a maximum benefit of forty (40) days per Member per Calendar Year.*	Yes	$300 per admission. Subject to maximum benefit.
• Outpatient Treatment *Limited to a maximum benefit of forty (40) visits per Member per Calendar Year.* *Two (2) visits for partial care or respite care or a combination thereof, may be substituted for each (1) day of Inpatient hospitalization not used by the Member.* *Benefit maximum does not apply to visits for medication management.*	Yes	$15 per visit. Subject to maximum benefit.
Substance Abuse Services		
• Inpatient Detoxification (treatment for withdrawal)	Yes	$300 per admission
• Outpatient Detoxification *Unlimited visits.*	Yes	$15 per visit
• Inpatient Rehabilitation *Limited to a maximum benefit of $9,000 per Member per Calendar Year.*	Yes	$300 per admission. Subject to maximum benefit.
• Outpatient Rehabilitation Counseling*		
Group Therapy	Yes	$15 per visit. Subject to maximum benefit.
Individual, Family and Partial Care Therapy**	Yes	$20 per visit. Subject to maximum benefit.

Covered Services and Limitations	Prior Auth. Required*	Tier I HMO Benefit (Copayment)
Substance Abuse Services (continued) **Rehabilitation counseling services for all group, individual, family and partial care therapy is limited to a maximum benefit of $2,500 per Member per Calendar Year.* *** Partial Care Therapy refers to a coordinated Outpatient program of treatment that provides structured daytime, evening and/or weekend services for a minimum of four (4) hours per session as an alternative to Inpatient care.*		

The Calendar Year Copayment Maximum for Tier I HMO basic health services is 200% of the total premium rate the Member would pay if he were enrolled under a Health Benefit Plan without Copayments. A Copayment will not exceed more than 50% of the total cost of providing any single service to a Member, or, in the aggregate, not more than 20% of the total cost of providing all of the basic healthcare services as required by Nevada regulations. Tier I HMO benefits have a Calendar Year Copayment Maximum.

Contact HPN's Member Services Department at (702) 242-7300 or 1-800-777-1840, Monday through Friday from 8:00 AM to 5:00 PM, for the appropriate Calendar Year Copayment Maximum applicable to this Plan.

Please note: For Inpatient and Outpatient admissions, in addition to specified surgical Copayments and/or Coinsurance amounts, Member is also responsible for all other applicable facility and professional Copayments and/or Coinsurance amounts as outlined in the Attachment A Benefit Schedule.

Any and all amounts exceeding any stated maximum benefit amounts under this Plan do not accumulate to the calculation of the Calendar Year Copayment Maximum.

*PAR (Prior Authorization Required) – Except as otherwise noted, Covered Services not provided by the Member's Primary Care Physician require Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.

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

Domestic Partner Rider

This Domestic Partner Rider when attached to the Health Plan of Nevada ("HPN") Evidence of Coverage ("EOC") amends the document to include Dependent coverage for a Subscriber's Domestic Partner. The enrollment of a Subscriber's Domestic Partner is subject to the eligibility and enrollment requirements contained herein. Dependent coverage for a Subscriber's Domestic Partner is subject to the conditions, limitations and exclusions contained in the EOC, the Attachment A Benefit Schedule and any applicable Endorsements or Riders.

To be eligible to enroll as a Subscriber's Domestic Partner under this Rider, a person must on the date of enrollment meet the following criteria:

a. provide proof of cohabitation; and

b. have attained the age of consent in his state of residence; and

c. not be related by blood in any manner that would bar marriage in the state of the Domestic Partnership; and

d. have a committed and personal relationship and be considered part of the Subscriber's family; and

e. not currently be a party to a valid marriage or a Domestic Partnership with anyone other than the Subscriber; and

f. have registered as the Subscriber's Domestic Partner where such registration is available; and

g. not have been registered as a member of another domestic partnership within the last six months except in the case of death of a previous Domestic Partner; and

h. demonstrate financial interdependence between the Subscriber and the Domestic Partner by submission of proof of three of the following:

   (1) common ownership of real property or a common leasehold interest in property;

   (2) common ownership of a motor vehicle or a common auto insurance policy on a motor vehicle;

   (3) joint bank accounts or credit accounts;

   (4) designation as a beneficiary for life insurance or retirement benefits, or under the partner's will;

   (5) assignment of a durable power of attorney or health care power of attorney; or

   (6) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

A Domestic Partner is not eligible to enroll for coverage if they are eligible for Medicare.

Domestic Partner

If a Domestic Partner relationship terminates, the Subscriber must notify the Group in writing. A new Domestic Partner may not be enrolled under this Plan for at least six months after the termination of the previous relationship.

A Domestic Partner's dependent children are not eligible for coverage unless meeting the Eligible Dependent criteria as set forth in the EOC.

An enrolled Domestic Partner and any enrolled dependent children of the Domestic Partner are only eligible for COBRA Continuation Coverage subject to and coinciding with the Subscriber's COBRA qualifying event and the Subscriber's timely election of COBRA.

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3-Tier Outpatient Group Prescription Drug Benefit Rider SIO Covered Drug Option

Benefit Tiers

Tier I: Preferred Generic Covered Drugs

Member pays:
$10 Copayment per retail Plan Pharmacy Therapeutic Supply
$20 per Mail Order Plan Pharmacy Maintenance Supply

Tier II: Preferred Brand Name Covered Drugs without a Generic Covered Drug Equivalent

Member pays:
$20 Copayment per retail Plan Pharmacy Therapeutic Supply
$40 per Mail Order Plan Pharmacy Maintenance Supply

Tier III: Non-Preferred Generic or Brand Name Covered Drugs without a Generic Covered Drug Equivalent

Member pays:
$40 Copayment per retail Plan Pharmacy Therapeutic Supply

Legal Documents

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group's election of coverage under this optional Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Rider is a supplement to your Evidence of Coverage (EOC) and Attachment A, Benefit Schedule issued by Health Plan of Nevada, Inc. (HPN), and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN EOC and herein.

SECTION 1. Obtaining Covered Drugs

Benefits for Covered Drugs are payable under the terms of this Rider subject to the following conditions:

- A Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided in Section 1.2 herein.
- A Generic Covered Drug will be dispensed when available, subject to the prescribing Provider's "Dispense as written" requirements.
- Benefits for Self-Injectable and Orphan Covered Drugs as defined herein are payable subject to the applicable Tier I, Tier II or Tier III benefit level.

1.1 Plan Pharmacy Benefit Payments

Benefits for Covered Drugs obtained at a Plan Pharmacy are subject to the following benefit tiers, as applicable:

a) **Tier I applies when:**
   - a Preferred Generic Covered Drug is dispensed; and
   - any required Prior Authorization has been obtained.

b) **Tier II applies when:**
   - a Preferred Brand Name Covered Drug is dispensed which has no Generic Covered Drug equivalent; and
   - any required Prior Authorization has been obtained.

c) **Tier III applies when either of the following is dispensed:**
   - a Non-Preferred Generic Covered Drug; or
   - a Non-Preferred Brand Name Covered Drug which has no Generic Covered Drug Equivalent; and
   - any required Prior Authorization has been obtained.

d) **Mandatory Generic benefit provision applies when:**
   - a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Member will pay the Tier I Covered Drug Copayment plus the difference between the EME of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Plan Pharmacy for each Therapeutic Supply.

e) When a Maintenance Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I or Tier II Mail Order Plan Pharmacy benefit tier will apply per Maintenance Supply.

1.2 Emergency or Urgently Needed Services Prescription Drugs

a) **Dispensed by a Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the applicable Copayment amount, subject to (a), (b), (c) or (d) in Section 1.1.

b) **Dispensed by a Non-Plan Pharmacy:** When a Covered Drug is dispensed by a Non-Plan Pharmacy in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Non-Plan Pharmacy at the time the Covered Drug is dispensed, the full cost of the Covered Drug subject to Section 1.3 below.

1.3 Non-Plan Pharmacy Benefit Payments

a) In order that claims for Covered Drugs obtained at a Non-Plan Pharmacy be eligible for benefit payment, the Covered Drugs must have been dispensed in connection with Emergency Services or Urgently Needed Services. The Member must complete and submit a claim form with the prescription label and register receipt to HPN or its designee.

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

   1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's EME and the Tier I, II or III

Copayment amount. The Member is responsible for any amounts exceeding HPN's benefit payment.

2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to HPN's EME of the Generic Covered Drug less the Tier I Copayment. The Member is responsible for any amounts exceeding HPN's benefit payment.

3. No benefits are payable if HPN's EME of the Covered Drug is less than the applicable Copayment.

1.4 Mail Order Plan Pharmacy Benefit Payments

a) Benefits for a Maintenance Supply of Maintenance Drugs are available when dispensed by an HPN Mail Order Plan Pharmacy subject to the applicable Tier I or Tier II Mail Order benefit tier.

b) Information on how to obtain Mail Order Maintenance Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

SECTION 2. Limitations

2.1 Prior Authorization is required for certain Covered Drugs.

2.2 Mail Order benefits only apply to Maintenance Drugs as defined herein.

2.3 Benefits for certain Covered Drugs are limited to a specific number of Therapeutic Supplies during a Dispensing Period as defined herein. If the applicable number of Therapeutic Supplies is exceeded prior to the expiration of the Dispensing Period, no benefits are payable until the commencement of any following Dispensing Period.

2.4 A Plan Pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.

2.5 Benefits for prescriptions for Mail Order Maintenance Drugs submitted following HPN's receipt of notice of Group's termination will be limited to the appropriate Maintenance Supply from the date such notice of termination is received, to the Effective Date of termination of the Group.

2.6 Benefits for Prior Authorized and Medically Necessary Compounds as defined herein are payable according to the applicable Non-Preferred benefit level.

SECTION 3. Exclusions

No benefits are payable for the following drugs, devices and supplies as well as for any complications resulting from their use except when prescribed in connection with the treatment of Diabetes:

3.1 Any drug, supply or device which can be purchased without a prescription, including those prescribed by a licensed Provider;

3.2 Drugs which are available without charge under local, state, or federal programs, including Workers' Compensation programs, or approved clinical trial or study;

3.3 Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices;

3.4 Anorexic agents (weight reducing drugs), drugs prescribed for cosmetic purposes, hair growth, nicotine suppressants, infertility drugs or erectile dysfunction drugs;

3.5 Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Self-Injectable Covered Drugs;

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

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

3.8 Prescription Drugs dispensed prior to the Member's Effective Date of coverage or after Member's termination date of coverage under the Plan;

3.9 Prescription Drugs, including Covered Drugs dispensed by a Non-Plan Pharmacy, except in the case of Emergency Services and Urgently Needed Services;

3.10 Prescription Drugs, including Covered Drugs prescribed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services;

3.11 Over-the-counter drugs, multivitamins and nutritional supplements;

3.12 Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Rider;

3.13 Any refill in excess of the amount specified by the prescription order;

3.14 Any refill dispensed; 1) more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed; 2) as a result of a lost or stolen prescription; or 3) as a result of abuse, misapplication or breakage, whether accidental or intentional;

3.15 Medical supplies unless listed in the PDL, or Prior Authorized by HPN;

3.16 Prescriptions for Covered Drugs that exceed the applicable number of Therapeutic Supplies in a given Dispensing Period as determined by HPN;

3.17 Any drug that has been approved by the FDA for less than nine (9) months; unless Prior Authorized by HPN;

3.18 Compounds unless Prior Authorized by HPN or that are determined not to be Medically Necessary;

3.19 Any class of Prescription Drugs for which an over-the-counter therapeutic equivalent is available;

3.20 Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained; and

3.21 Drugs and medicines approved by the FDA for experimental or investigational use except when prescribed for the treatment of cancer or chronic fatigue syndrome under a clinical trial or study approved by the Plan.

SECTION 4. Glossary

4.1 "Brand Name Drug" is a Prescription Drug which is marketed under or protected by:

- a registered trademark; or
- a registered trade name; or
- a registered patent.

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

4.3 "Copayment" is the predetermined amount shown in this Rider that the Member is responsible for paying directly to the Plan Pharmacy for each Therapeutic Supply of a Covered Drug at the time the prescription is dispensed. Copayments or any amounts paid in addition to the Copayment do not apply to the annual out-of-pocket Copayment Maximum set forth in the Attachment A, Benefit Schedule, if any.

4.4 "Covered Drug" is a Brand Name or Generic Prescription Drug which:

- can only be obtained with a prescription;
- has been approved by the Food and Drug Administration ("FDA") for general marketing, subject to 3.17 herein;
- is dispensed by a licensed pharmacist;
- is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
- is a Prescription Drug that does not have an over-the-counter therapeutic equivalent available; and
- is not specifically excluded herein.

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

4.6 "Eligible Medical Expense (EME)" for purposes of this Rider, means the Plan Pharmacy's contracted cost of the Covered Drug to HPN but not more than the actual charge to the Member.

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

4.8 "Mail Order Plan Pharmacy" is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Preferred Maintenance Drugs to Members by mail.

4.9 "Maintenance Drug" is a Preferred Covered Drug prescribed to treat certain chronic or life-threatening long-term conditions as determined by HPN, such as the following: Diabetes, Arthritis, Heart Disease and High Blood Pressure. For purposes of this Rider, Maintenance Drugs do not include Self-Injectable or Orphan Covered Drugs other than those for the treatment of Diabetes.

4.10 "Maintenance Supply" is the quantity, as determined by HPN, of a Preferred Maintenance Drug for which Mail Order benefits are available for a specified number of Copayments, and may be less than but shall not exceed a 90-day supply.

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

4.12 "Non-Preferred" for purposes of this Rider, means those Covered Drugs not included on the Preferred Drug List.

4.13 "Orphan Drugs" means a Prescription Drug for the treatment or prevention of a rare disease or condition as determined by the FDA. A rare disease is one that affects less than 200,000 people in the U.S. or one that affects more than 200,000 people but for which there is no reasonable expectation that the cost of developing the drug and making it available will be recovered from sales of that drug in the U.S.

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

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

4.16 "Prescription Drug" is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.

4.17 "Self-Injectable" Covered Drug is an injectable Covered Drug which is to be administered subcutaneously or intramuscularly which does not require administration by a licensed Practitioner. Injectable Covered Drugs meeting this definition are considered Self-Injectable Covered Drugs even when administered by a licensed Practitioner or someone other than the Member.

4.18 "Therapeutic Supply" is the quantity of a Covered Drug for which benefits are available for a single applicable Copayment and may be less than but shall not exceed a 30-day supply.

Important Notice regarding the Preferred Drug List (PDL)

The Preferred Drug List (PDL) is a list of FDA-approved Generic and Brand Name Prescription Drugs established and maintained by HPN. The PDL is developed and maintained by the HPN Pharmacy and Therapeutics (P&T) Committee, which is comprised of Primary Care and Specialty Physicians, pharmacists and other healthcare Providers.

The Committee meets at least annually and as needed throughout the year to evaluate the PDL and review new and existing categories of drugs. Drugs and drug classes are evaluated based upon FDA-approved indications, effectiveness, adverse effect profile, patient monitoring requirements, patient dosage and administration guidelines, impact on total healthcare costs, and comparison to other drugs on the PDL. Cost becomes a determining factor when minimal or no differences exist when comparing effectiveness with other drug specific parameters.

The Committee uses medical and clinical literature, relevant patient utilization and experience, current therapeutic guidelines, economic data, and Provider recommendations in its decision-making process.

HPN's PDL is subject to change during the year based on P&T Committee decisions and recommendations.

Questions about HPN's PDL should be directed to the Member Services Department at (702) 242-7300 / 1-800-777-1840.

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Preventive Vision Care Services Rider

The Member Handbook and Evidence of Coverage ("EOC") between the Group and Health Plan of Nevada, Inc. (HPN), to which this Preventive Vision Care Services Rider ("Rider") is attached and incorporated therein, is hereby amended to include the following preventive vision care services:

SECTION 1. Definition

1.1 "Plan Provider" means an ophthalmologist or optometrist who has agreed under an independent contract to provide Preventive Vision Care Services to Members.

SECTION 2. Vision Care Services

2.1 Subject to all definitions, terms and conditions in the EOC, a Member is entitled to receive the Preventive Vision Care Services set forth in this Rider. The Member shall be entitled to Preventive Vision Care Services while Member is enrolled in Health Plan.

2.2 Examination

One vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each 12 consecutive calendar months period.

2.3 Copayment

A copayment of $10 is required for each vision examination by a licensed Plan Provider.

SECTION 3. Exclusions

In addition to any other applicable exclusions in the EOC, benefits shall not be provided for:

a) lenses, frames and/or contact lenses;

b) orthoptics or vision training;

c) medical or surgical treatment of the eyes;

d) services or materials provided under Workers' Compensation;

e) eye examination required as a condition of employment or by a government body, and

f) low vision aids.

SECTION 4. General Provision

4.1 This Rider shall be effective on the effective date of the EOC.

4.2 This Rider shall terminate upon termination of the EOC and under the same terms and conditions specified in the EOC. Upon such termination, Member shall cease to be entitled to any benefits provided under this Rider.

4.3 Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the EOC, other than as set forth in this Rider.

Good Health Begins With Prevention!

Health Plan of Nevada (HPN) has developed Prenatal, Pediatric, Childhood and Adult Preventive Healthcare Guidelines based on recommendations from national healthcare organizations. As your partner in healthcare, HPN recommends the following **minimum** screenings, testing and immunizations for you and your family members to maintain good health. Your HPN provider may recommend additional or more frequent testing based on individual health needs. These guidelines do not represent standards of care for an individual patient. The use of these guidelines should not substitute for the professional judgment of individual healthcare providers, which takes into account the unique problems and circumstances of individual patients.

Please take some time to review these guidelines. You are the most important member of the healthcare team, so please consult with your provider if you or a family member needs any of the recommended screenings, tests or immunizations. Remember **"an ounce of prevention is worth a pound of cure!"**

Pediatric Preventive Guidelines

Birth to 15 months	
Screening	Height and weight Head circumference Vision/hearing subjective Additional screening is needed for certain high risk groups.
Anticipatory Guidance/ Parent Counseling	**Diet:** breastfeeding, nutrition, especially iron intake **Injury Prevention:** child safety seats, smoke detector, sleep positioning, sun safety, hot water heater temperature, stairway gates, window guards, pool fence, storage of drugs and chemicals, toy safety **Sleep Positioning:** age newborn to 6 months **Poison Control:** poison control number and ipecac syrup **Dental Health:** baby bottle tooth decay **Violence Prevention:** anger management, management of depression **Other areas:** effects of passive smoking
Ages 15 months to 4 years	
Screening	Height and weight Blood pressure (beginning at 3 years) Eye exam (age 4) Hearing screen (age 4) Additional screening is needed for certain high risk groups.
Anticipatory Guidance/ Parent Counseling	**Diet and Exercise:** sweets and between meal snacks, foods with iron, and low sodium, balancing calories, exercise **Injury Prevention:** safety belts, smoke detector, hot water heater temperature, window guards, pool fence, bike helmets, storage of drugs and chemicals, matches, and firearms **Poison Control:** poison control number and ipecac syrup **Dental Health:** Tooth brushing and dental visits **Violence Prevention:** anger management, management of depression **Other areas:** effects of passive smoking **Remain alert for:** vision problem, dental decay, early loss of teeth, mouth breathing

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Preventive Guidelines

Pediatric Preventive Guidelines

Ages 5-10 years	
Screening	Height and weight Blood pressure Hearing screen (ages 5-6) Vision screen Eye exam for certain conditions (ages 5-6) Additional screening is needed for certain high risk groups.
Anticipatory Guidance/ Parent Counseling	**Diet and Exercise:** fat, cholesterol, sweets and in between meal snacks, low sodium, balancing calories, exercise, and calcium **Injury Prevention:** safety belts, smoke detector, storage of firearms, drugs and chemicals, matches, bike helmets **Violence Prevention:** anger management, management of depression **Substance Abuse:** tobacco and alcohol and other drugs **Dental Health:** regular tooth brushing and dental visits **Remain alert for:** vision disorders, hearing problems dental decay, and mouth breathing
Ages 11-21 Years	
Screening	Height and weight Blood pressure Hearing screen Vision screen Urine test Additional screening is needed for certain high risk groups.
Anticipatory Guidance/ Parent Counseling	**Diet and Exercise:** fat, especially saturated fat, cholesterol, sodium and balancing calories **Substance Abuse:** stopping or preventing the use of tobacco, alcohol and other drugs, and driving while under the influence of alcohol or other drugs **Sexual Practices:** sexual development and behavior, preventing sexually transmitted diseases, using condoms, preventing unintended pregnancies and contraceptive options **Injury Prevention:** safety belts, safety helmets, violent behavior, firearms use, and **Violence Prevention:** anger management and depression management **Dental Health:** regular tooth brushing, flossing, and dental visits **Other areas:** skin protection from ultraviolet light **Remain alert for:** tooth decay, gum disease

Recommended Well Child Visits

Age:	**Visits per Year:**
Birth up to 15 months (Infancy)	At least 8 visits. Birth, 2 to 4 days, by 1 month, 2 months, 4 months, 6 months, 9 months and 12 months
15 months through 4 years (Early childhood)	At least 5 visits - 15, 18 and 24 months, 3 and 4 years
5 through 10 years (Middle childhood)	At least 4 visits.
11 through 21 years (Adolescence)	One visit each year with additional visits as needed, for recommended immunizations

Recommended Childhood Immunizations

Each year, the Centers for Disease Control and Prevention (CDC) publishes the schedule for the numbers of shots that children and teens need to receive in order to manage their health. Please review this immunization schedule on the CDC website at www.cdc.gov.

Prenatal Care Guidelines*

Please review HPN's Prenatal Care Guidelines that have been developed based on the recommendations of the American College of Obstetricians and Gynecologists (ACOG) to ensure a healthy start for HPN's newest members. These guidelines represent the minimum recommended standards of care. Different needs of individual women will require more visits and/or testing. Your doctor will also discuss any personal health factors and additional preventive measures recommended for your specific situation.

HPN recognizes that the health of an infant begins before birth and therefore encourages early prenatal care. HPN wishes you the best in bringing in the newest addition to your family!

VISITS	ASSESSMENTS	LABORATORY/DIAGNOSTIC TESTS	COUNSELING
First Prenatal Visit	• Age <18 Years; >35 Years • Genetic & Obstetric History • Dietary Intake • Tobacco/Alcohol/ Drug Use • Risk Factors For Intrauterine Growth Retardation and Low Birth Weight • Prior Genital Herpetic Lesions • Prior C-Section Births	• Blood Pressure • Hemoglobin & Hematocrit • ABO/Rh Typing • Rh(D) & Other Antibody Screen • VDRL/RPR • Hepatitis B Surface Antigen (HBsAg) • Urinalysis for Bacteriuria • Gonorrhea Culture/Chlamydia Culture • Rubella antibodies filter • Counseling and testing for HIV	• Nutrition • Tobacco Use • Alcohol & Other Drug Use • Safety Belts • Physical Abuse, when indicated • Risks of HIV Infection • Genetic and ethnic diseases
Follow up Visits[1] (frequency of visits based on patient need)	• Blood Pressure • U/A Dipstick for Protein/Glucose	***16-20 Weeks:*** • Maternal Serum Alpha-Fetoprotein (MSAFP)[2] ***18-20 Weeks:*** • Ultrasound (at 18-20 weeks) ***24-28 Weeks:*** • Hgb/Hct • Oral Glucose Tolerance Test (1 hour) • Rh(d) Antibody (Rhogam) **35-37 Weeks:** • GBS Screening	• Nutrition • Safety Belts • Upcoming Tests • Physical Abuse, when indicated ***24-28 Weeks:*** • Schedule appointment to meet pediatrician and register for prenatal classes • Receive fetal movement instructions ***38-39 Weeks:*** • Schedule post partum visit

VISITS	ASSESSMENTS	LABORATORY/DIAGNOSTIC TESTS	COUNSELING
Post-Partum Visit	• Within 42 days of normal vaginal delivery • Within 14 days of discharge for C-section post surgical evaluation & 42 days for post-partum evaluation • Family planning counseling • Screening for post partum depression		• Family planning counseling

[1]Scheduling of visits and the frequency of the individual preventive services listed herein are left to clinical discretion, except for those indicated at specific gestational ages.

[2]Women with access to counseling and follow-up services, skilled high-resolution ultrasound and amniocentesis capabilities and reliable, standardized laboratories.

Adult Preventive Healthcare Guidelines

Adult preventive guidelines are established minimum standards of care for people in good health. Specific illnesses and risk factors may indicate a need for more frequent tests or a different type of test. If you have individual needs (i.e. family or personal history, chronic illness) that require additional or different preventive health measures, your doctor will inform you. Your doctor will review your preventive health needs with you and make the appropriate changes to the standard schedule and frequency of tests.

	Age	Frequency
Primary Screening		
Blood Pressure Check	Begin at 18 Years	Every 2 Years – more often as indicated
Cholesterol & High Density Lipoprotein (Lipids)	Begin at 20 Years	Every 5 Years – more often as indicated
Obesity Screening	Begin at 15 Years	Periodic measurement of height, weight, and body mass
Colorectal Cancer Screening (Average Risk) • Fecal occult blood testing (FOBT) • Flexible sigmoidoscopy • Barium enema • Colonoscopy • Annual FOBT and flexible sigmoidoscopy	Begin at 50 Years	As indicated by specific test: Annually Every 5 years Every 5 years Every 10 years Every 5 years

	Age	Frequency
Colorectal Cancer Screening (High Risk)	Begin earlier than age 50 and/or undergo more frequent testing depending on risk factors.	Same frequency as those at average risk unless it is indicated more often.
Type 2 Diabetes Mellitus Screening	Begin at 18 years	As indicated for those with high blood pressure or high lipids.
Human Immunodeficiency Virus (HIV) Testing	Begin at 18 years	As indicated for those at risk for HIV.
Skin Examination	Begin at 18 years	Annually
Vaccinations		
Tetanus-Diphtheria/Tetanus Diphtheria-Pertussis (Tdap)	Begin at 15 Years	Every 10 Years – more often and for different age groups as indicated.
Influenza Immunizations		
• Individuals with chronic conditions	As needed	Annually
• Individuals with no chronic conditions or those not at high risk as stated below	Begin at 50 Years	Annually
• Residents/employees of chronic care facilities, healthcare providers in hospitals and outpatient settings, and women in the 2nd and 3rd trimester of pregnancy.	As needed	Annually
Pneumococcal Immunizations		
• Individual with chronic condition	18 Years and older as needed	Once and one-time revaccination 5 years later for individuals less than 64 years old.
• Individual with no chronic condition	65 Years	Once and one-time revaccination if first dose was given before 65.
Measles, Mumps, and Rubella (MMR)	Adults born during or after 1957.	One or two doses as needed.
Varicella (Chicken Pox)	As needed	Two doses recommended for adults with no evidence of immunity or have no history of chicken pox.
Human Papillomavirus Virus (HPV)	Women 26 years and under who have not previously completed the vaccine series.	Three doses
Education/Counseling		
Preventive Counseling for Tobacco Use, Nutrition, Exercise, Sexual Behavior, Substance Abuse, Injury Prevention and Dental Care	As needed	Ongoing as need exists

Preventive Guidelines

	Age	Frequency
Counseling for Advanced Directives	As needed	When indicated
Depression Screen	As needed	When indicated
Women's Health		
Pap Smear	No later than 21 years	When indicated
Pelvic Exam	No later than 21 years	When indicated
Chlamydia Screening	25 years and younger	When indicated
Gonorrhea Screening	All sexually active women	When indicated
Syphilis Infection Screening	Women at increased risk	When indicated
Clinical Breast Examination	20-39 years old 40 years and older	Every 3 years Annually
Mammography	40-49 years old	Every one to two years annually
Counseling for Post Menopausal Hormone Replacement Therapy	When needed	Onset of Menopause (either natural or surgical)
Osteoporosis Screening	65 years and older	As indicated and starting at age 60 when indicated.
Preventive Cardiovascular Aspirin Therapy Counseling	As indicated	As indicated
Men		
Prostate Specific Antigen Test & Digital Rectal Examination	50 years and older and 45 years and older for those at high risk	As indicated
Gonorrhea Screening	All sexually active men	When indicated
Syphilis Infection Screening	Men at increased risk	When indicated
Abdominal Aortic Aneurysm (AAA)	Between 65 and 75 years of age and for men who have ever smoked	Once
Preventive Cardiovascular Aspirin Therapy Counseling	As indicated	As indicated

You may access the most current electronic version of the document by accessing the HPN website at www.healthplanofnevada.com

Advance Directives

DURABLE POWER OF ATTORNEY

DECLARATION OF LIVING WILL

NOTE: This document is not intended as a substitute for legal advice. You should seek qualified legal guidance to assist you in completing and executing an Advance Directive in accordance with the law.

Introduction

There may come a time when you will be seriously injured or become gravely ill and unable to make healthcare decisions for yourself. You may wish to choose in advance what kinds of treatments are administered and whether or not life support systems should be maintained or withdrawn.

Most states allow a competent adult to execute a document which allows him or her to accept or refuse treatment in the event that he or she has a terminal condition and is not able to make decisions for himself or herself. Many states do not specify the particular form that a directive must follow to be effective, but you should check the laws in your own state to be sure. However, we have included information for you on where you can get forms which may be available.

Glossary

Advance Directive - an instruction, such as a Declaration/Living Will or Durable Power of Attorney for Healthcare Decisions, to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

Attorney In Fact - a person authorized by another to act in his place either for some particular purpose, as to do a particular act, or for the transaction of business in general which is not of a legal nature.

Life-sustaining Treatment - a medical procedure or intervention that uses mechanical or other artificial means to sustain, restore or supplant a vital function. It only artificially postpones the moment of death of a patient in a Terminal Condition whose death is imminent or will result within a relatively short time without the application of the procedure. The term does not include the administration of medication or the performance of a medical procedure considered to be necessary to provide comfort or care, or to alleviate pain.

Terminal Condition - an incurable and irreversible condition caused by injury, disease or illness that would result in death without the application of life-sustaining procedures, according to reasonable medical judgement. The application of life-sustaining procedures serves only to postpone the moment of the patient's death.

Types of Advance Directives

A ***Declaration/Living Will*** is one type of Advance Directive. A Declaration/Living Will directs your attending physician to withdraw treatment that only prolongs a Terminal Condition. To be valid under law, a Declaration/Living Will must be signed by you as the declarant and must also be signed by two witnesses who 1) are not related to you by blood or marriage, 2) are not mentioned in your will and 3) would have no claim on your estate.

In addition the Declaration/Living Will may not be witnesses by your physician or by anyone working for your physician. If you are in a healthcare facility at the time you sign the Declaration/Living Will, you may not use as a witness any other patient, or employee of the facility if they are involved in providing direct patient care to you or are directly involved in the financial affairs of the facility. The signatures of the witnesses do not have to be notarized to make the Declaration/Living Will a valid legal document.

A ***Durable Power of Attorney for Healthcare Decisions*** may also be executed. This document allows you to appoint someone to make a variety of healthcare decisions for you should you become unable to do so. Requirements under the law are very specific for properly executing this

document, and you should seek qualified legal guidance to assist you in completing and executing an Advance directive in accordance with the law.

Advance Directives as Part of your Permanent Medical Record

Once you have executed an Advance Directive of any kind, please notify your physician and provide a copy of it to him or her so that it may be made a part of your permanent medical record.

Upon learning of the existence of an Advance Directive, a physician must make reference to the fact that you have an Advance Directive in your permanent medical record.

Frequently Asked Questions

How long is an Advance Directive valid?

Generally, any Advance Directive is effective until it is revoked. You may want to consider initialing and dating your Advance Directive periodically to show that it still expresses your wishes. You may revoke your Advance Directive at any time and in any manner, without regard to your mental or physical condition. A revocation is effective when your attending physician or other healthcare provider receives notice of the revocation from you or from a witness to the revocation. Pursuant to the law, to the extent that a Durable Power of Attorney for Healthcare or Declaration/Living Will conflicts with a directive or treatment decision executed under the law, the instrument executed later in time controls.

What will happen if I become terminally ill and I am unable to make healthcare decisions by myself, yet I haven't executed an Advance Directive?

In preparation for this possibility, you should, at the very least, make your wishes known to those you love. Laws in your state may give a "surrogate decision maker" the authority to consent to the withholding or withdrawal of life-sustaining treatment for you. (This consent must be in writing and attested by two witnesses.)

A "surrogate decision maker" is, in order of authority;

- your spouse;
- your adult child or, if you have more than one child, a majority of the adult children who are reasonably available to consult;
- your parents;
- your adult sibling or, if you have more than one adult sibling, a majority of the adult siblings who are reasonably available to consult;
- or your nearest other adult relative by blood or adoption who is reasonably available to consult.

If a class of "surrogate decision makers" entitled to consent is not reasonably available to consult and competent to decide, or declines to decide, the next class is authorized to make the decision. An equal division in a class does not authorize the next class to decide.

What if my doctor objects to the withholding or withdrawal of life-sustaining treatment?

Healthcare providers have varying beliefs regarding the implementation of an individual's Advance Directive. An attending physician or other provider of healthcare who is unwilling to honor your Advance Directive must take all reasonable steps as promptly as possible to transfer your care to another physician or healthcare provider.

How will my execution of an Advance Directive affect my health and life insurance policies?

The making of an Advance Directive does not affect the sale, purchase or issuance of a life insurance or annuity policy, nor does it affect the terms of an existing policy. It also cannot be prohibited or required as a condition of being insured for, or receiving, healthcare.

What are our policies on the administration of life-sustaining treatment?

As a company we are committed to the preservation of life and the alleviation of suffering. If, however, you wish to have life-sustaining treatment withheld or withdrawn in the event you become terminally ill, we will make every effort to see that your wishes are honored. If you have already executed an Advance Directive, please give a copy to your doctor(s) to be placed in your medical record.

Where can I obtain a Declaration/Living Will or Durable Power of Attorney for Healthcare Decisions form?

Forms are available from a variety of sources, including some physicians, attorneys, and healthcare facilities.

Once you have completed an Advance Directive, discuss your decisions with your family, next of kin, or other responsible parties, and give your attorney and each one of your doctors a copy to be placed in all of your medical records. It is also advisable to keep a copy with you at all times.

Conclusion

It is difficult for people to make good decisions when they are under pressure or emotional strain, particularly in areas where there are no clear-cut answers about life-sustaining treatment. These issues require a great deal of discussion and careful thought. The information provided here has been presented in the hope that you will discuss it with your doctor and others and come to a decision that is right for you or someone you love.