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Personnel
Beverly Glenn

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BARBARA REED
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BY [signature] DEPUTY

93/94 Hospital Health Plan Contract

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COORDINATED CARE OPTIONS of NEVADA

HOSPITAL HEALTH PLAN

GROUP SUBSCRIPTION AGREEMENT

FOR A NON-FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION PLAN

BY AND BETWEEN

Hospital Health Plan, Inc., a Nevada non-profit corporation (hereinafter called "Hospital Health Plan")

AND

DOUGLAS COUNTY
(hereinafter called "Group").

In consideration of the mutual covenants herein contained and intending to be legally bound hereby and in consideration of the payment of premium charges to Hospital Health Plan by Group in accordance with the terms and provisions contained in this Agreement, Hospital Health Plan will arrange for professional and hospital services in accordance with the provisions, terms, limitations and exclusions contained in the Evidence of Coverage on behalf of eligible enrollees and their eligible family members who elect to enroll with Hospital Health Plan.

This Agreement includes this document and addenda, the original application, the Evidence of Coverage and has been executed on the date shown and shall become effective on July 1, 1993.

HOSPITAL HEALTH PLAN

By: _____
Allan E. Hanssen
President
Chief Operating Officer

Date: 5-28-93

GROUP

By: _____
(Authorized Signature of Group)

Date: 6/3/93

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DEFINITIONS

A. Subscriber: An employer or other person purchasing a health care plan for him/herself or others pursuant to this written Group Subscription Agreement with Hospitah Health Plan.

B. Enrollee: An individual (Employee or Dependent) who has voluntarily enrolled in this health care plan.

C. Effective Date of Coverage: Date an enrollee's coverage under the Group Subscription Agreement begins.

D. Grace Period: A period which begins the first day an enrollee's premium becomes due and extending for a period of 30 days thereafter.

E. Family Member: The term family member shall have the same meaning as the dependent as used in this Agreement and the Evidence of Coverage.

F. Open Enrollment: A period of time (usually the 30-day period prior to the contract anniversary date) during which eligible employees have the option to choose between (elect) Hospital Health Plan and any other options available to them at the time.

G. Waiver of Coverage Form: The means by which a enrollee may choose not to elect coverage for himself/herself and/or his/her dependent(s) at time of enrollment eligibility.

H. Evidence of Insurability Form: The means by which an employee and/or his/her dependent(s) may apply to reinstate their eligibility to enroll in the Plan.

I. TERM OF AGREEMENT

This Agreement becomes effective on July 1, 1993 at 12:01 a.m. Standard Time in Reno, Nevada and will remain in effect for twelve (12) consecutive months ending June 30, 1993 or until discontinued, terminated or voided as provided.

II. PREMIUM CHARGES

A. Premium Rate Schedule:

TYPE OF COVERAGE:	TOTAL PREMIUM*	GROUP CONTRIBUTION	ENROLLEE CONTRIBUTION
Individual Enrollee	$ 167.80	_____	_____
Enrollee Plus One Family Member	$ 344.70	_____	_____
Enrollee Plus Two or More	$ 482.94	_____	_____

* Includes Medical Benefit Plan, Dental, Vision, and Prescription coverage (if elected) as set forth in the Group Application.

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RETIREES			
One Medicare	$ 105.46	Retiree	$ 222.36
Two Party-Both Medicare	$ 210.92	Retiree + One	$ 478.51
Two Party-One Medicare	$ 348.02	Retiree + Two	
Family-Two Medicare	$ 289.48	or more	$ 615.68
Family-One Medicare	$ 426.58		

Medicare rates assumes Medicare Parts A & B. Includes Medical Benefit Plan, Vision, and Prescription coverage as set forth in the Group Application.

B. Premium Due Dates and Payments: On or before the first day of each month of coverage hereunder (the "Premium Due Date"), Group shall pay Hospital Health Plan the applicable Total Premium set forth in Section A for each enrollee and for each of their family members. Premiums shall be calculated by Hospital Health Plan from current records as to the number of Individual enrollees and family members currently enrolled. If this Agreement is terminated for any reason, the Group shall be liable for all premiums due and payable. Only enrollees for whom payment is received by Hospital Health Plan shall be eligible for services and benefits hereunder and only for the period covered by such payment. In the event the Group fails to notify Hospital Health Plan of enrollees and/or eligible dependents who lose eligibility due to termination of employment or other circumstance within ninety (90) days after the effective date of loss of eligibility, premium reimbursement or credit will be limited to a ninety (90) day period or to the last episode of care received by the enrollee and/or eligible dependent(s), whichever occurs last.

C. Acceptance of Late Premium Payment: Any premium payments made by Group after the grace period and accepted by Hospital Health Plan shall be subject to a late penalty charge of 1.5% of the total premium due and calculated for each thirty (30) day period the amount due remains outstanding.

D. Revision of Premium: The Board of Governors of Hospital Health Plan (subject to such approvals by governmental agencies as may be required by law) may revise the premiums set forth in Section A on the first and subsequent anniversary of the effective date of this Agreement. Any such revision of premium shall become applicable for all enrollees on the effective date of the revision. In the event of such revision, Hospital Health Plan shall give at least sixty (60) days prior general notice which notice shall be considered to have been given when mailed to the Group or its agent at the address on the records of Hospital Health Plan.

E. Reports and Records: Group shall make available to Hospital Health Plan for inspection such employment, payroll and other personnel records which may have a bearing upon the eligibility status of an employee.

III. ELIGIBILITY, ENROLLMENT AND TERMINATION OF COVERAGE:

A. Eligible enrollees (employees) and their family members shall be those

persons who meet the criteria set forth in the Group Application or who were covered under the prior plan under COBRA provisions immediately prior to the effective date of this Agreement subject to approval by Hospital Health Plan.

B. Enrollment of each enrollee (employee) and his or her eligible family members shall be executed by Hospital Health Plan upon proper notice from the Group (by the receipt of a completed enrollment application approved by the Group) in a timely fashion. Timely shall be defined as within sixty (60) days after the eligibility date for coverage of the enrollee and his or her eligible family members. However, at no time will an enrollment application be accepted by Hospital Health Plan which was not first submitted to the Group within thirty (30) days after the employee and his/her eligible family members' eligibility date for coverage. Employees and dependents who do not enroll in a timely manner are ineligible for subsequent coverage unless they submit "Evidence of Insurability" for Hospital Health Plan's approval.

C. There will be an open enrollment period prior to the effective date of each contract year. Eligible employees may choose between Hospital Health Plan and any option available to them at the time. Eligible employees may add eligible dependents during open enrollment.

D. Employees and/or their dependent(s) who have previously waived coverage with Hospital Health Plan are <u>not</u> considered eligible to enroll in the Plan unless they submit Evidence of Insurability and have their eligibility approved by Hospital Health Plan.

E. Termination of each enrollee (employee) and his or her eligible family members shall be deleted from coverage by Hospital Health Plan upon receipt of proper written notice from the Group in a timely fashion. Timely shall be defined as within sixty (60) days after the effective date of the termination of the enrollee and his or her eligible family members. Notification of any continuation privileges required under applicable law shall remain the responsibility of the Group.

IV. <u>COVERAGE</u>

Medical Benefit Plan Chosen: Standard Plan
Optional Rider Benefits: Prescription $8

V. <u>GROUP CONTRIBUTION</u>

Group shall offer Hospital Health Plan to all eligible enrollees of Group on terms no less favorable with respect to contribution by the Group toward premium than those applicable to such other health benefits coverage as may be available to all eligible enrollees through the Group. The Group contribution set forth in Section II. A. of the premium rate schedule and on the Group Application shall not be changed

during the term of the Agreement unless such change is agreed to in writing by Hospital Health Plan. If, however, the Group's contribution to such other coverage as may be available through the Group is increased during the term of the Agreement, Group agrees to increase its contribution to Hospital Health Plan coverage effective the same date as such increase to such other coverage becomes effective.

VI. INELIGIBLE ENROLLEES:

In the event the Group fails to notify Hospital Health Plan of the ineligibility of any enrollee for whom the Group has made the premium payments required as specified in Section II, such prepayment will only be credited to Group if Hospital Health Plan or participating physicians have not provided or paid for covered services for the ineligible enrollee before such notice but in no event later than ninety (90) days subsequent to the date such enrollee became ineligible (See paragraph II.B.).

VII. NOTICE

A. Any notice hereunder to be given to the Group or to Hospital Health Plan shall be addressed to:

"Group's Physical Address, please:"

_____ Hospital Health Plan
_____ ATTN: Chief Operating Officer
_____ 400 S. Wells Ave.
_____ Reno, Nevada 89502

Notice shall be mailed certified, return receipt requested.

B. Hospital Health Plan recognizes that the Group may work with an Agent/Broker of Record who, individually or through a firm, arranges for a variety of types of Group insurance coverage. Hospital Health Plan acknowledges that preference by the Group and wishes to work cooperatively with the named Agent/Broker of Record. It is the responsibility of the Group to identify the current Agent/Broker of Record on the Group Application. If, during a contract period, the Group wishes to change the Agent/Broker of Record, notice shall be provided, in writing, to Hospital Health Plan in advance of the change. Hospital Health Plan will make the change effective on the first day of the month following receipt of proper written notice from the Group. The Agent/Broker of Record must hold the appropriate valid health insurance license required by Nevada regulation.

VIII. TERMINATION OF AGREEMENT:

A. AT OPTION OF PARTIES: This Agreement may be terminated by Hospital Health Plan without cause by giving at least sixty (60) days written notice. The group may terminate this Agreement without cause by giving Hospital Health Plan at least thirty (30) days written notice. In such event, benefits hereunder shall terminate for all enrollees as of the date of termination of this Agreement.

B. FOR CAUSE:

1. This Agreement may be terminated by Hospital Health Plan for any of the following reasons:

i. If any premium payment required to be made by the Group is not received by the Premium Due Date, subject to a thirty (30) day grace period, Hospital Health Plan may terminate the Agreement upon written notice.
ii. Upon written notice in the event of insolvency or bankruptcy of the Group.
iii. Upon written notice if Group ceases to operate or relocates out of the service area.
iv. Material breach of any of the terms and provisions of this Agreement by Group. In this event Hospital Health Plan shall, at its election and upon thirty (30) days prior written notice to Group, terminate this Agreement.

2. This Agreement may be terminated by Group for any of the following reasons:

i. Upon written notice in the event of insolvency or bankruptcy of Hospital Health Plan.
ii. Upon written notice upon revocation of Hospital Health Plan's Certificate of Authority.
iii. Material breach of any of the terms and provisions of this Agreement by Hospital Health Plan upon thirty (30) days written notice.

IX. SUBROGATION

A. Group agrees that unless otherwise classified by applicable regulations or statutes the benefits to be issued by Hospital Health Plan under the terms of this Agreement shall be secondary coverage to any and all other sources of recovery to include any and all Group policies of insurance or other benefits available to enrollees or enrollee's representatives and any policies of insurance insuring any other party liable to enrollees or otherwise responsible for the payment of medical expenses or other damages of enrollees.

B. In the event that there are any other available sources of recovery, Hospital Health Plan shall have an unqualified right of recovery or reimbursement against any and all other benefits arising out of any policy or any other source or recovery available to enrollee or enrollee's families or representative(s) and shall have the right to seek reimbursement or recovery up to the full amount of the actual medical, hospital or other health service bills for which Hospital Health Plan has issued benefits.

C. Hospital Health Plan and Group acknowledge that the premiums and costs of the benefits which are being rendered for the benefit of the Group enrollees have been computed and based in part upon the right of Hospital Health Plan to make recoveries under the terms and conditions of the Group Subscription Agreement.

D. In the event that a plan member fails to fully cooperate and assist Hospital Health Plan in the recovery, payment and/or application for the sources described in Section IX, Part B recovery which include other Group insurance coverage and/or third party recovery, Hospital Health Plan shall have the right to bill and otherwise seek recovery of such charges/costs from non-cooperating member.

E. The group agrees in conjunction with Hospital Health Plan to fully apprise all plan members of the rights of Hospital Health Plan under the terms of the Subrogation and Right to Reimbursement Agreement contained in the Evidence of Coverage which is attached and a part of the Agreement.

F. The Group further agrees to fully cooperate with Hospital Health Plan and to take any and all actions necessary for the enforcement of the Subrogation and Right to Reimbursement Agreement contained in the Evidence of Coverage which is attached and a part of the Agreement.

X. GENERAL PROVISIONS

A. Amendments: Neither party to this Agreement may amend the Agreement without prior written consent of the other party, which consent shall not be unreasonably withheld.

B. Strict Performance: No failure by either party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement or to exercise a right or remedy shall constitute a waiver. No waiver of any breach shall affect or alter this Agreement, but each and every covenant, condition, agreement and term of this Agreement shall continue in full force and effect with respect to any other existing or subsequent breach.

C. Entire Agreement: This Agreement constitutes the entire agreement between the parties and contains all the agreements between the parties with respect to the subject matter hereof. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

D. Governing Law: This Agreement shall be construed and enforced under and in accordance with the laws of the State of Nevada.

E. No Third Party Rights: Except as specifically provided elsewhere in this Agreement, nothing in this Agreement shall be construed as creating or giving rise to

any rights to any third parties or any persons other than the parties hereto.

F. Construction of Terms and Headings: Words used in this Agreement shall be read as the masculine, feminine, or neuter gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this Agreement.

G. Authority to Adopt Policies: Hospital Health Plan may adopt such policies, procedures and rules to promote orderly and efficient administration of this Agreement.

H. Arbitration: As a condition precedent to any right of action hereunder, if any dispute or controversy of any nature shall arise between the group, any subscriber, enrollee, heir-at-law or personal representative of the same as the case may be and Hospital Health Plan, its employees or agents, or any contracting providers, their employees or agent, the dispute or controversy shall be settled by arbitration before one arbitrator selected from a panel of arbitrators of the American Arbitration Association in accordance with Commercial Arbitration Rules of the American Arbitration Association, and judgement on the award entered in any court with jurisdiction.

I. Relationship to Providers: The relationship between Hospital Health Plan and its providers is that of an independent contractor and not that of employer/employee. Hospital Health Plan is not liable for the acts or omissions of any Provider or of any person who undertakes to render services to enrollees of Hospital Health Plan.

J. Assignment: Neither the Group nor a subscriber or enrollee may assign the benefits provided pursuant to this Agreement and the applicable Evidence of Coverage. Any attempted assignment by the Group, an enrollee or subscriber shall be ineffective.

K. Acts of God: If war, public disaster, public emergency, general epidemic, or other similar conditions prevent Providers of Services from providing services to enrollees, Hospital Health Plan shall attempt to provide for such services in a comparable manner to the extent possible . If not possible, then Hospital Health Plan may terminate this Agreement and the only obligation of Hospital Health Plan shall be to refund the amount of the unearned prepaid premiums held by Hospital Health Plan on the date such event occurs.

L. Identification Cards: An identification card shall be issued to each enrollee for identification purposes only and must be presented whenever services are sought. Possession of an identification card confers no right to services or guarantee of payment by Hospital Health Plan. A person must be eligible and premiums must be paid for services to be covered. An identification card is not a guarantee of current

eligibility. Persons receiving services to which they are not entitled shall be charged and responsible for payment for the services. The identification card is the property of Hospital Health Plan and its return may be requested at anytime.

ATTACHMENT 1

ELIGIBILITY PROVISIONS

DOUGLAS COUNTY CONTRACT RENEWAL

See corrected Attachment 1

ENROLLMENT / PAYMENT PROVISIONS

GROUP NAME: Douglas County

ELIGIBILITY STATUS:

SUBSCRIBERS

- [X] ACTIVE EMPLOYEES
- [X] RETIRED EMPLOYEES
- [ ] MEDICARE ELIGIBLE EMPLOYEES
- [X] PERMANENT FULL-TIME EMPLOYEES SCHEDULED TO WORK AT LEAST 30 HOURS PER WEEK.
- [X] PERMANENT PART-TIME EMPLOYEES SCHEDULED TO WORK AT LEAST 20 HOURS PER WEEK.
- [X] EMPLOYEES ARE ELIGIBLE TO CONTINUE GROUP COVERAGE WHILE ON AN APPROVED TEMPORARY INACTIVE STATUS. (PLEASE SUBMIT A COMPLETE DESCRIPTION WITH THIS APPLICATION.)
- [ ] OTHER (PLEASE SUBMIT A COMPLETE DESCRIPTION.)

DEPENDENTS:

- [X] STANDARD PLAN REQUIREMENTS (SEE ELIGIBILITY REQUIREMENTS ON PAGE 2).
- [ ] OTHER (PLEASE SUBMIT A COMPLETE DESCRIPTION).

COMMENCEMENT OF COVERAGE:

NEWLY HIRED/ELIGIBLE EMPLOYEES:

- [ ] 1st OF MONTH FOLLOWING DATE OF HIRE/ELIGIBILTY
- [X] 1st OF MONTH FOLLOWING 1mo. DAYS FROM DATE OF HIRE/ELIGIBILTY NON-CONTRACT
- [ ] DATE OF HIRE/ELIGIBILTY
- [ ] _____ DAYS FOLLOWING DATE OF HIRE/ELIGIBILTY
- [ ] OTHER (PLEASE SUBMIT A COMPLETE DESCRIPTION.)
- [X] FOM following 3mos. for contract employee

incorrect

NEWLY ELIGIBLE DEPENDENTS:

- [ ] STANDARD PLAN REQUIREMENTS (SEE ELIGIBILITY REQUIREMENTS ON PAGE 2).
- [X] OTHER (PLEASE SUBMIT A COMPLETE DESCRIPTION WITH APPLICATION). Newborn is eff. d.o.b., newly acquired spouse or step children eff. first of mo. following acquisition.

TERMINATION PROVISIONS:

- [X] LAST DAY OF THE MONTH IN WHICH THE EMPLOYEE CEASES TO BE ELIGIBLE UNDER GROUP ELIGIBILITY PROVISIONS.
- [ ] MIDNIGHT, THE DATE OF TERMINATION.
- [ ] OTHER (PLEASE SUBMIT A COMPLETE DESCRIPTION WITH THIS APPLICATION INCLUDING INDIVIDUAL CONVERSION PROVISIONS).

PAYMENT PROVISIONS:

- [X] FULL MONTHLY PREMIUMS w/ exception for newborns
- [ ] IF COMMENCEMENT OF COVERAGE FALLS ON:
  - -THE 1st THROUGH THE 15th OF THE MONTH, FULL PREMIUMS ARE DUE;
  - -THE 16th THROUGH THE END OF THE MONTH, NO PREMIUMS ARE DUE.
- [ ] IF TERMINATION OF COVERAGE FALLS ON:
  - -THE 1st THROUGH THE 15th OF THE MONTH, NO PREMIUMS ARE DUE;
  - -THE 16th THROUGH THE END OF THE MONTH, FULL PREMIUMS ARE DUE.
- [X] OTHER (PLEASE SUBMIT A COMPLETE DESCRIPTION WITH THIS APPLICATION).

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- [X] Newborn premium charged from F.O.M. coinciding with or next following DCB -4-

Corrected Attachment 1

Eligibility Provisions

Douglas County Contract Renewal

COORDINATED CARE OPTIONS
NEVADA

HOSPITAL HEALTH PLAN

October 10, 1993

Memo to: Frank Guisti, Jr.

From: Leslie O'Day

Re: Douglas County

Hospital Health Plan agrees to administer the Douglas County Contract according to your request. The Group Subscription Agreement for 1993-94 has not yet been signed and returned by Douglas County. In order to implement these modifications I'd like to suggest that your memo dated October 8th requesting these modifications be attached as an addendum to the Douglas County Group Subscription Agreement and returned to Hospital Health Plan for implementation.

Please let me know if I can be of any assistance.

C: Beverly Glenn

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100 S. Wells Avenue Reno, Nevada 89502 (702) 329-0101 FAX (702) 329-3723

Sedgwick

Sedgwick Consulting Group
5190 Neil Road, Suite 400, Reno, Nevada 89502
PO Box 7575, Reno, Nevada 89510-7575
Telephone 702 826-8450, Facsimile 702 826-9424

October 8, 1993

To: Leslie O'Day
Hospital Health Plan

Fr: Frank R. Guisti, Jr.

Re: Douglas County

Beverly Glenn called me yesterday to advise me that she had recently talked to you about the issue of adding coverage for previously eligible dependents who lost their other coverage and the payment of premium for newly acquired dependents.

The insurance committee for Douglas County would like to have those two issues handled by Hospital Health Plan the same way that they are handled by United of Omaha.

Under the United of Omaha, if an employee does not request coverage for eligible dependents when he/she initially elects coverage (because those dependents have coverage through another employer) an evidence of insurability form must be completed and submitted to United of Omaha, if those dependents loose that other coverage and the employee requests coverage more than 30 days after their initial effective date.

If an employee acquires a new dependent (newborn child, marriage or adoption) the effective date of coverage is the date of acquisition under United of Omaha if the employee elects coverage within 30 days of the date of acquisition. If the employee requests the addition of dependent coverage more than 30 days after the date of acquisition, an evidence of insurability form must be completed and submitted by the employee.

United of Omaha does not prorate premium or use a cutoff date to determine if premium is due for a particular month. They require payment of premium from the first of the month coinciding with or next following the effective date of coverage.

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Sedgwick

The effective date of coverage for individuals who the employee has submitted evidence of insurability on is the date coverage is approved by their underwriting department.

As Broker/Consultant of Record for Douglas County, I respectfully request that you provide me with a letter stating that Hospital Health Plan will use the same administrative procedures and premium payment provisions that United of Omaha uses on the Douglas County account for the situations that I have identified.

I will be meeting with the insurance committee on Wednesday, October 13. I would like to have your letter in my office by 5 P.M. on Tuesday, October 12 so that I can deliver copies to the insurance committee on the following day.

Beverly asked me to provide you with a copy of the minutes from the September 1, 1993 group insurance committee meeting.

If you should have any questions in regards to my request please do not hesitate to give me a call.

cc: Beverly Glenn

COORDINATED CARE OPTIONS of NEVADA

HOSPITAL HEALTH PLAN

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COPAYMENT PRESCRIPTION DRUG PLAN RIDER

In consideration of the payment of an additional premium, as set forth in the Declarations Page of the Group Enrollment Contract, the Group Enrollment Contract and Group Medical and Hospital Service Evidence of Coverage (EOC), are hereby amended as follows:

DEFINITIONS

Unless otherwise defined herein, all terms in this Rider shall have the same meaning as defined in the EOC.

Participating Pharmacy is a pharmacy within the Service Area which has entered into a service agreement with Coordinated Care Options of Nevada/Hospital Health Plan (CCO/HHP) to provide Prescription Medications to Members. A list of Participating Pharmacies will be provided to Subscribers by CCO/HHP.

Prescription Medications (Prescriptions) means, for purposes of this Rider, the following: 1) Any medicinal substance that bears the legend "Caution: Federal Law prohibits dispensing without a prescription," except for medicinal substances classified as Exempt Narcotics under state law *(Federal Legend Drugs)* 2) any medicinal substance that may only be dispensed by a prescription under state law *(State Restricted Drugs)* 3) any medicinal substance that must be mixed, compounded or otherwise prepared by a Registered Pharmacist and that has at least one ingredient that is a Federal Legend or State Restricted Drug in a therapeutic amount *(Compounded Medications)* and, 4) with respect to all of the above, which can only be dispensed pursuant to a prescription of a Physician and subject to the limits contained in the CCO/HHP Drug Formulary.

Generic Drug means an alternative to a brand name drug which is listed in the CCO/HHP Drug Formulary.

CCO/HHP Drug Formulary means a listing of Prescription Medications which are approved for use by CCO/HHP. The CCO/HHP Drug Formulary shall be subject to periodic review and modification by CCO/HHP from time to time without advance notice or approval from Group or Members.

BENEFIT

Prescriptions which are prescribed for the Member's use by a Participating Physician and which are obtained by the Member at a Participating Pharmacy shall be covered consistent with the CCO/HHP Drug Formulary, subject to the provisions of the EOC and its attachments.

To obtain benefits, a Member must present his/her CCO/HHP identification card, and comply with the requirements of this Rider and EOC, including payment of all Copayments. If a Member does not present his/her CCO/HHP identification card, Member shall be responsible for paying the full cost of the prescription dispensed.

In the event of an Emergency, a Member may fill a Prescription at a non-participating pharmacy and CCO/HHP shall reimburse Member up to a five (5) day supply, upon presentation of the following information to CCO/HHP:

1. Copies of the receipts, etc. acceptable to CCO/HHP showing Prescription number, name of drug, date filled, pharmacy name, name of the Member for whom the Prescription was written, and proof of payment.
2. Member identification number as it appears on the CCO/HHP identification card.
3. A statement, acceptable to CCO/HHP, describing why a Participating Pharmacy was not utilized.

All such claims must be filed within sixty (60) days of Member's receipt of the filled Prescription or such claims will be deemed waived.

Prescriptions shall be filled with Generic Drugs. The only exceptions to the use of Generic Drugs are those cases where 1) no Generic Drug exists, 2) no Generic Drug is in stock, 3) the CCO/HHP Drug Formulary directs the dispensing of a brand name drug.

CONTRACEPTIVE PRODUCTS

Notwithstanding anything above to the contrary, the following contraceptive products are covered pursuant to this Rider, subject to the following conditions. The dispensing of each of the following shall constitute a separate prescription, subject to a Copayment, and is the maximum amount that may be dispensed at any one time:

ORAL CONTRACEPTIVES: A one (1) cycle supply of oral contraceptives or a consecutive 28 day supply, whichever is less; and

DIAPHRAGM: One diaphragm device per twelve (12) month period, unless otherwise prescribed by a Participating Physician.

DIABETIC AND OSTOMY CARE PRODUCTS

Notwithstanding anything above to the contrary, the following diabetic and ostomy care products are covered pursuant to this Rider, subject to the following conditions. The dispensing of each of the following shall constitute a separate prescription, subject to a Copayment, and is the maximum amount that may be dispensed at any one time:

INSULIN/SYRINGES:	30-Day Supply of diabetic needles and syringes; and a 30-Day Supply or one 10 ml. bottle of injectable insulin, whichever is greater.
DIABETIC TEST SUPPLIES:	30 Day Maximum Allowable: **Chemstrips** - up to 4 units, but not to exceed 130 Chemstrips; **Lancets** - 1 unit — 200/unit; **Glucometer** - Maximum Allowable, 1 per lifetime — $45 maximum toward purchase of machine.
OSTOMY CARE PRODUCTS:	30-Day Maximum Allowable: **Bag/Pouch** - 1 unit of 30 or 1 unit of 10; **Flanges** - 2 units of 5; **Adhesive** - 1 unit; **Paste** - 1 unit; **Night Bags** - 1 unit; **Inserts** - 1 box every two months.

Ostomy Care Products obtained from a Pharmacy other than the following shall be the financial responsibility of the Member: **Don's Pharmacy**, 175 W. 6th Street, Reno, Nevada 89503. Telephone: (702) 329-1775 or (800) 525-9119

COPAYMENTS

The Member shall be responsible for a $8.00 Copayment for each Prescription dispensed in accordance with this Rider. In addition, a Member shall be responsible for the difference between the retail cost of the brand name drug and the cost of its Generic Drug equivalent if a brand name drug is dispensed in a manner other than in accordance with this Rider.

Member must pay the Copayment to the Participating Pharmacy at the time the Prescription is filled, for each Prescription or refill dispensed, up to a consecutive 30-day supply unless otherwise limited by the drug manufacturer's packaging or this Rider.

EXCLUSIONS

1. Over-the-counter drugs and medicines and other substances not requiring a prescription even if ordered by a Participating Physician via a prescription, drugs consumed in a Physician's office, except as otherwise provided herein or in the EOC.

2. Fertility drugs and injectable medications which are not listed in the CCO/HHP Drug Formulary including, but not limited to, biological serum, blood and blood plasma, oxygen, immuno-suppressive agents and drugs, antihemophilic factors, including TPA, acne preparations, laxatives and immunization agents, unless otherwise provided herein or pursuant to the EOC.

3. Intrauterine devices ("IUD's"), condoms and any other contraceptive devices, supplies and products not specifically provided for herein.

4. Drugs which are listed by the Food & Drug Administration as "less than effective."

5. Experimental and investigational drugs, including drugs labeled "Caution-Limited by Federal Law to investigational use," as well as drugs either not approved by the Federal Drug Administration as "safe and effective" as of the date this Rider was issued to Group or, if so approved, which are intended to treat a medical condition for which the U.S. Food and Drug Administration (FDA) has not specifically approved its use, whether used on an inpatient or outpatient basis.

6. Prescriptions which are available without charge under local, state or federal programs, including Worker's Compensation or Occupational Disease Laws, or medication for which a charge is not made.

7. Quantities in excess of a 30-day supply. Prescriptions requiring quantities in excess of the above amount shall be completed on a refill basis, exept as otherwise provided in the CCO/HHP Drug Formulary.

8. Cosmetics, dietary supplements (vitamins; except those prescribed pre-natal vitamins listed on the CCO/HHP Formulary), diet pills, health or beauty aids.

9. Replacement of lost or stolen medications. Replacement of an existing Glucometer even if obtained while not covered by CCO/HHP.

The above benefits are subject to all other terms and provisions set forth in the Group Enrollment Contract and EOC, except where clearly inconsistent in which case the provisions of this Rider shall govern.

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COORDINATED CARE OPTIONS of NEVADA

HOSPITAL HEALTH PLAN

May 28, 1993

Frank Guisti, Jr.
Sedgwick James Co.
P.O. Box 7575
Reno, NV 89510-7575

Re: Douglas County Renewal Date: July 1, 1993

Dear Frank:

Thank you for renewal of coverage for Douglas County. We look forward to serving this group's health care needs for another year.

As previously indicated, employees and/or their dependents will continue to be allowed to enroll outside the normal 31-day window of eligibility, by submitting "Evidence of Insurability" [EOI - Medical Questionnaire]. The enclosed agreement clarifies this benefit for your employees.

We enclose two copies of HHP/CCO's Group Subscription Agreement (GSA), the new EOC, a Prescription Rider, Eligibility and any other riders applicable to this group. These are part of the contract upon renewal. Please replace the group's 1992 contract with a complete copy of the attached for the group's records. **Return the hole-punched copy of the GSA, signed by the appropriate group representative, in the enclosed self-addressed-stamped envelope.**

Note that general benefits have not changed. However, since this EOC clarifies the Plan's exclusions and limitations, pay particular attention to Attachment A, Schedule of Benefits and Exclusions. We enclose a Comparison of Benefits or Limitations, showing specific differences between the new and old EOC.

In addition to the appropriate signature on the front page of the hole-punched copy to be returned to HHP, we ask that the following sections of the Agreement be completed:
Page 2, Section II. A.: Please provide the amount of premium the employer will be contributing for each type of coverage (i.e. individual subscriber, subscriber plus one, family coverage, etc.) under the column heading "Group Contribution".
Page 5, Section VII. A.: Please provide the appropriate address to be used for official notice.

Continued payment of premiums and acceptance of benefits is treated by CCO/HHP as evidence of acceptance of the contract.

Should you require any additional information or have questions, please do not hesitate to call.

Sincerely,
COORDINATED CARE OPTIONS/HOSPITAL HEALTH PLAN

Jamie Killeen, Sales Service Representative
Encl.
copy: Neldon Demke

320568

400 S. Wells Avenue Reno, Nevada 89502 (702) 329-0101 FAX (702) 329-3723

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ATTACHMENT C
COPAYMENT SCHEDULE

STANDARD PLAN

The following benefits are available to Hospital Health Plan enrollees when arranged by your Hospital Health Plan Primary Care Physician. All services must be approved by Hospital Health Plan. **All services associated with a non-covered or denied benefit will be the enrollee's financial responsibility.**

Hospital Services (other than inpatient services for alcoholism and drug abuse and mental disorders; see separate listing for those benefits).

1. Inpatient hospital services include:
   a. Semi-private room and board (private room when medically necessary);
   b. General nursing care (special duty nursing when medically necessary), and;
   c. Other services, supplies and facilities as prescribed by a Plan physician such as: operating room and related facilities; Intensive Care Unit and related services; X-ray services; laboratory and other diagnostic tests; drugs, medications, biological, anesthesia and oxygen; rehabilitation services (60 day limit per year); physical therapy, speech therapy for aphasia, occupational therapy, radiation therapy, inhalation therapy and chemotherapy; blood and blood plasma and its administration; special diets when medically necessary.
   d. (See separate listing for limits on kidney disease treatment). Personal convenience items are not covered.
   e. In an inpatient rehab stay, long-term physical, occupational, speech or rehabilitative therapy which is not expected to provide significant improvement within a 60-day period, that is, progress toward the established rehabilitative goal, is unlikely or can be achieved in a less intense or outpatient setting, will result in a denial of benefits.

   Enrollee Copayments - $500

2. Outpatient hospital services include:
   a. Radiotherapy, chemotherapy, speech therapy, rehabilitation therapy, physical therapy, and occupational therapy;
   b. Dialysis, and;
   c. Other services and supplies as listed under "Inpatient hospital services" listed above.
   d. See separate listing for limits on kidney disease treatment.

   (NOTE: Outpatient hospital services do not include emergency room services.)
   Enrollee Copayments - NO CHARGE

3. Outpatient surgery, 24-hour observation and medical short stay.
   Enrollee Copayments - $250

Hospice Services

This benefit is available to terminally ill enrollees in either a home setting or Plan facility. This does not include enrollees who require the services of a hospital or skilled nursing facility. Hospital Health Plan will assist the terminally ill patient and the family with arrangements for hospice care. These benefits will be in line with home care benefits when prior authorized. The maximum benefit would be six (6) months per lifetime.

Enrollee Copayments - NO CHARGE

Medical Office Visits

All general care by a Primary Care Physician is covered. Other specialty medical care by Plan physicians and other health professionals is covered when directed by a Primary Care Physician and authorized by Hospital Health Plan. This includes:

1. Preventive services;
2. Surgical procedures;
3. Some radiology and pathology;
4. Anesthesia;
5. Psychiatric care;
6. Podiatry;
7. Consultation and treatments with specialists with referral from Primary Care Physician;
8. Care from other health professionals with referral from Primary Care Physician and approved by Hospital Health Plan.
9. Emergency care, and;
10. Physician home visits as necessary.

See separate listings below for coverage of oral surgery, mental health, alcoholism and drug abuse services.

Enrollee Copayments - $15

Physician Services in Hospital

If an enrollee were admitted to a Plan hospital, all services of Plan physicians and Plan hospital personnel required or directed by Plan physicians including:

1. Surgical procedures;
2. Anesthesia, and/or;
3. Consultations and treatment by referral physicians.

No physician services will be covered if the Plan determines that your hospitalization is not medically necessary.

Enrollee Copayments - NO CHARGE

Plastic/Reconstructive Services

Plastic or reconstructive surgery will be a covered benefit only when necessary to restore normal physiological function. Reconstructive surgery after a mastectomy is covered if the mastectomy was performed while the person was enrolled with Hospital Health Plan. Surgery must begin within three years of the mastectomy. The reconstruction will include two protheses subject to the Hospital Health Plan guidelines. Applicable copayments are in effect according to the service provided as defined.

X-Ray and Laboratory Services

All prescribed x-ray and laboratory tests, services and materials, including complex imaging, diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, mammograms, laboratory tests, and therapeutic radiology services. Complex and extensive diagnostic studies must be approved by the Medical Director of Hospital Health Plan.

Enrollee Copayments - NO CHARGE

Maternity and Pregnancy Care and Newborn Care

Full hospital and medical services including prenatal and postpartum care. Included, when authorized by HHP and arranged by a Plan Physician before and during confinement and during the postpartum period, are hospital services, including use of delivery room and nursery, medical services, including operations, special procedures such as cesarean section,

anesthesia, injectable, x-ray and laboratory services, and services needed for complications resulting from conditions caused by the following: an injury or sickness not directly related to the pregnancy,; or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or if the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination. There is no coverage for any termination of pregnancy other than indicated and abortions necessary to save the life of the mother in accordance with established Plan protocols.

Coverage for newborns includes: preventive health care, coverage of injury or illness, services for congenital defect and birth abnormalities, functional repair or restoration of any body part when necessary to achieve normal body functions. Cosmetic surgery to improve appearance is not covered.

Necessary transportation will be covered as stated under the section "Ambulance and Other Transportation Services".

Enrollee Copayments - $500 per admission and $15 per office visit

Infertility Services

Treatment of infertility is limited to procedures which have demonstrated efficacy for the condition involved. All such services require prior authorization by Hospital Health Plan. All authorized fees are covered to a maximum of $5,000 per lifetime. Infertility drugs are not a covered benefit. Applicable copayments are in effect according to the service provided as defined.

Infertility services will be determined by the Plan.

Oral Surgery And Other Dental Services

Surgical services for treatment of disease and injury of the jaw or any structures surrounding the jaw. Treatment of fractures and dislocations of the jaw or any facial bone.

1. The following services would be covered for children: neoplasia; congenital; developmental; accidental; defects or abnormalities of facial structures, if the child was born to parents who were covered by Hospital Health Plan at the time of the child's birth. The child must be eligible at the time of service.
   Enrollee Copayments - NO CHARGE

2. Treatment of temporomandibular joint dysfunction (TMJ) is limited to medically necessary services and is covered up to 50% of reasonable and customary charges. Enrollees shall pay up to 50% of physician's fees. All services must be referred by the Primary Care Physician and authorized by the Medical Director, not to exceed $2,500 copayment from the enrollee.
   Enrollee Copayments - 50% of Physician's Fee, Not to Exceed $2,500

Preventive Health Services

1. Services for well-baby and child care, including hospital visits for newborn babies, Primary Care Physician office visits and immunizations.
   Enrollee Copayments - $15

2. Routine periodic health assessments for children after age two (2) and initial health appraisal and periodic assessments for adult enrollees including tests routinely made in connection with such examinations. Also includes immunizations as required.
   Enrollee Copayments - $15

NOTE: Examinations for employment, insurance, recreation, school acceptance or licenses are not covered benefits. Physical examination, reports, or related services for the purpose of obtaining or maintaining employment, licenses, insurance or school admission are not covered benefits.

3. Allergy testing, including allergens and their administration.
Enrollee Copayments - $15

4. Family planning services, including sterilization and treatment for limited infertility. Charges for artificial insemination and invitro fertilization are not covered, but normal maternity benefits apply if conception results from these procedures.
Enrollee Copayments - $15

5. An annual pap smear or pelvic examination for females without referral from a primary care physician.
Enrollee Copayments - $15

6. Mammograms (initial screening for ages 35 to 40 and annually for women over 40).
Enrollee Copayments - $15

Health Education

Hospital Health Plan is involved with health education services. Watch for your "Healthy Connection" newsletter.
Enrollee Copayments - Nominal charge per course

Home Health Care

Home care by physician-supervised health professionals (including registered nurses, physical, respiratory, occupational, and speech therapists, and registered dieticians), is provided. It must be prescribed and arranged by your Primary Care Physician and approved by Hospital Health Plan. Home care does not include meals, custodial care or housekeeping services. Drugs and medications will be covered in accordance with any applicable supplemental rider to this Evidence of Coverage. Over the counter aids and supplies, drugs and medications will not be covered.
Enrollee Copayments - NO CHARGE

Mental Health Services

Hospital Health Plan provides mental health treatment based on a short-term treatment model, according to accepted psychiatric diagnostic criteria, and is reviewed for quality assurance and effectiveness by Hospital Health Plan's Health Services Department.

Inpatient treatment will be provided for acute crisis intervention, and only after evaluation and referral by a participating provider and authorization by Hospital Health Plan's Health Services Department.

Institutional care for the primary purpose of controlling a member's environment will only be covered for acute phase of illness.

Counseling for chronic marital relationship conflicts are not covered unless associated with acute phase of mental or emotional disorders.

1. Outpatient mental health services for evaluation and therapy are covered up to a maximum of 25 visits per calendar year. This requires a referral from your Primary Care Physician and approval from Hospital Health Plan.
Enrollee Copayments - $25

2. Inpatient hospitalization for mental illness is covered for a maximum of 42 days which is the total lifetime benefit. All stays require your Primary Care Physician's approval as well as Hospital Health Plan authorization. Only 21 days per calendar year will be approved. Inpatient treatment will be provided only for acute crisis intervention. When mental health benefits have expired, the member may not appeal to Hospital Health Plan for extensions of Plan benefits.
Enrollee Copayments - $500

NOTE: All services must be ordered or arranged by your Primary Care Physician and authorized by Hospital Health Plan. While referral may be made for non-medical services such as vocational rehabilitation or employment counseling, those services are not a covered benefit.

Alcohol and Drug Abuse Services

Hospital Health Plan manages Alcohol and Drug Abuse treatment by utilizing day or evening outpatient treatment programs. If inpatient medical detoxification is needed, you must use Hospital Health Plan's providers and receive authorization from Hospital Health Plan.

All treatment for alcohol and drug abuse is planned prior to admission to any program, facility or hospital.

Results have indicated that partial hospitalization programs and outpatient services are as effective or in many cases, more effective than traditional inpatient programs.

One advantage of this program is helping the member get the needed treatment without disruption to his/her home life.

1. Treatment for withdrawal from physiological effects of alcohol or drugs--$1500 maximum benefit per calendar year.
Enrollee Copayments - NO CHARGE

2. Admission to a Plan hospital or facility--$9,000 maximum benefit per calendar year.
Enrollee Copayments - $500

3. Outpatient Counseling for a person, group or family not admitted to a facility--$2,500 maximum benefit per calendar year.
Enrollee Copayments - $15

4. Care for conditions mandated by any federal, state, or local law or licensing board are not a covered benefit. Care mandated at a public facility is not a covered benefit.

   For alcohol and drug abuse, maximum benefit for all of the above services combined--$39,000 per lifetime.

NOTE: All treatment for alcohol and drug abuse requires authorization from your Primary Care Physician and Hospital Health Plan. Vocational rehabilitation or employment counseling is not included in this benefit.

Skilled Nursing Facility Services

Skilled nursing care in a skilled nursing facility, when medically necessary, up to 30 days per calendar year. Must be approved by Hospital Health Plan as a supplement to or substitution for inpatient hospitalization. Nursing home benefits do not include care for alcoholism, drug abuse or mental or nervous disorders (except as specifically provided for by Hospital Health Plan), custodial care, household care, or personal convenience items.
Enrollee Copayments - NO CHARGE

Ambulance And Other Transportation Services

Medically necessary ambulance or other transportation service required in an emergency. You may be responsible for the charges if it was not an emergency condition or services were not approved by Hospital Health Plan.

Enrollee Copayments - $50

Emergency Services In Or Outside The Service Area

If you or your dependents need emergency medical or hospital services, and the time required to reach a Hospital Health Plan provider would result in a significant risk of permanent health damage, medically necessary services furnished by a physician, oral surgeon, or hospital or emergency facility personnel are covered for the time period of the emergency. **Hospital Health Plan will make the final decision on any question as to whether an emergency existed and for what time period.**

Routine Follow-up care at emergency room facilities is not covered. Follow-up care should be provided by your Primary Care Physician. See Sections C and D of Attachment A for instructions on actions you should take in an emergency.

Medical and hospital services in or outside the service area are limited to situations in which care is medically necessary, required immediately and unexpectedly unless otherwise authorized by Hospital Health Plan.

Enrollee Copayments - $75

NOTE: Health care that is provided out of the service area because of circumstances which could have been reasonably foreseen prior to departure from the service area will not be covered. This includes normal, full term delivery outside the service area. In addition, in order for medical and hospital services outside the service area to be covered, your travel, or that of your dependent, must be for some purpose of medical treatment which must be authorized by Hospital Health Plan.

1. If you are temporarily away from home and an emergency occurs, go to the nearest medical facility. Notify your Primary Care Physician within 24 hours or as soon as possible.
2. Follow-up treatment and continuing care should be provided in your service area and may not be covered if provided outside the service area.

Urgent Care Services

Urgent care services, as defined by this EOC, are a covered benefit. Members must notify his/her Primary Care Physician or HHP as shown in Section E(1) and F(1-2) of Attachment A of this EOC.

In-Service Area: Urgent Care Services are those treatments that would normally be obtained in a contracted physician's office. In-service area Urgent Care Services must be obtained at a contracted Urgent Care Provider. The maximum benefit and copayment amount will differ according to the type of Urgent Care Provider.

Out-of-Service Area: Urgent Care Service are those treatments that would normally be obtained in a contracted physician's office but, because the illness or injury is of a sudden and unforeseen nature and occurs while the member is out of HHP's service area, are obtained at a non-contracted provider site. Out-of-Service Area urgent care services must be obtained either at an Urgent Care Center or a Hospital Emergency Room. The maximum benefit and copayment amount will differ according to the type of Urgent Care Provider.

Urgent Care Center

Enrollee Copayment - $25 No Maximum Benefit

Hospital Emergency Room

Enrollee Copayment - $75

$250 Maximum benefit, including the enrollee copayment.

Durable Medical Equipment

DME supplies will be provided at the discretion of Hospital Health Plan and will be covered in connection with member's effective date for those members who require them.

Orthopedic shoes (unless it is a supportive device that is an integral part of a leg brace) are not covered.

Outpatient oxygen and its administration when specifically authorized by Hospital Health Plan. Long term oxygen use (after six months) is not covered.

Outpatient consumable medical supplies such as elastic stockings, garter belts, arch supports, slings, ace bandages, corsets, trusses, corrective orthopedic shoes, elastic splints, and braces or other similar elastic support devices are not covered.

Enrollee Copayments - NO CHARGE

Prosthetic Devices

Prosthetics will be covered for the following conditions: the condition necessitating the device must occur after the effective date of the member's enrollment in the Plan (except in certain conditions for mastectomy - see paragraph below). The device must be necessary to maintain life, to restore a missing part of the body, or to significantly improve a bodily function.

If a covered mastectomy is performed on a member, coverage will include the expense for breast reconstructive surgery and for up to two (2) prosthetic devices subject to all the terms and conditions of this EOC. If reconstructive surgery is begun within three (3) years after the mastectomy, coverage will be extended to the member or ex-member for all eligible charges for such reconstructive surgery as would have been provided at the time of the mastectomy. If the surgery is begun more than three (3) years after the mastectomy, the benefits provided are subject to all the terms, conditions and exclusions contained in the EOC in effect at the time of the reconstructive surgery.

Other prosthetic devices are limited to the initial artificial limbs, penile implants, and eyes (excluding their repair or replacement).

Enrollee Copayments - NO CHARGE

Chiropractic Care

Provision for spinal manipulation and adjustments are limited to acute short-term treatment. This requires a referral from your Primary Care Physician and authorization from Hospital Health Plan. The member will be responsible for a copayment for each visit.

Chiropractic treatment covers short term treatment of back, shoulder, and neck injuries or diseases when they interfere with normal function. Hospital Health Plan does not cover treatment of chronic or recurring conditions or chronic conditions (that is more than six months of treatment).

Enrollee Copayments - $15

Podiatry Services

Podiatry is covered for medically necessary surgical procedures. Routine foot care, such as the treatment of corns and calluses are not covered unless required for neurocirculatory conditions. Orthotics and orthoses are not covered.

Enrollee Copayments - $15

Other Services

1. **Blood**
   Blood and blood plasma and its administration as ordered by your physician is a covered benefit.
   Enrollee Copayments - NO CHARGE

2. **Orthopedic Appliances**
   Casts, splints, braces and crutches will be covered following acute trauma or surgery. Pre-operative dental braces, splints or other orthopedic appliances are not covered.
   Enrollee Copayments - NO CHARGE

3. **Therapy**
   Treatment by a physical, speech or occupational therapist when ordered by your Primary Care Physician and authorized by Hospital Health Plan, may be covered if the service is not duplicated by other agencies or has not been provided previously for the same condition.

   Occupational, physical, and speech therapy must be approved by the Plan and are benefits when needed in connection with acute or traumatic illness or disease.
   Enrollee Copayments - NO CHARGE

4. **Kidney Disease Treatments**
   Dialysis services up to $30,000 during any 12 consecutive months; however, these benefits will be coordinated with benefits available under the Medicare program for qualified persons with permanent kidney failure.
   Enrollee Copayments - NO CHARGE

5. **Human Transplantation Services**
   Transplantation will be covered for kidneys with coordination of benefits available under the Medicare program for qualified enrollees with end-stage renal disease. Liver transplantation will be provided for juvenile biliary atresia. Immunosuppressive drugs are covered for these services no greater than one year.
   Enrollee Copayments - NO CHARGE

6. **Drugs**
   Investigational drugs, their administration, or related services, are not a covered benefit.

Participating Providers

As a member of Hospital Health Plan, you agree to use only the participating providers on our approved list.

Participating providers are not authorized to speak on behalf of Hospital Health Plan as to what constitutes a covered service.

EXCLUSIONS

Except as specifically provided in your Schedule Benefits and in any supplemental benefit endorsements which your group may choose and which are included as part of this Evidence of Coverage, the following services and benefits are excluded from coverage

(a) Services of non-Participating Providers, except in an Emergency, for Out-of-Area Urgently Needed Services, or when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(b) Services which are not medically necessary or not required in accordance with accepted standards of medical practice in the Service Area.

(c) Cosmetic surgery or medical procedures, defined as any plastic or reconstructive surgery or medical procedures done primarily to improve the appearance of any portion of the body, and from which no substantial clinical improvement in physiologic function could be reasonably expected. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation or reduction procedures, rhinoplasty and associated surgery, epikeratophakia surgery, any augmentation or reduction procedures or correction of facial or breast asymmetry (except breast asymmetry will be provided pursuant to Section A 17 of this Attachment A), treatment of male-pattern baldness or hair treatment, keloid scar therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions, unless medically necessary, and complications (except infection or disease resulting from excluded cosmetic surgery or medical procedures). For the purpose of this EOC, psychological factors (for example, for self-image, difficult social or peer relations) are not relevant and do not constitute a physical bodily function or Medical Necessity.

(d) Surgical or invasive treatment (including gastric balloon), or reversal thereof, gastric stapling, for reduction of weight regardless of associated medical or psychological conditions, including treatment of complications resulting from surgical treatment of obesity, unless determined by HHP to be Medically Necessary by HHP in advance of treatment.

(e) Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations as well as penile implants and services and supplies related to implants.

(f) Services to reverse voluntary surgically-induced infertility, sex-change procedures, maternity services related to a Member serving in the capacity of a surrogate mother, in vitro fertilization, Prescription (infertility) Drugs, and any infertility or infertility services, except as otherwise specifically set forth elsewhere in the EOC.

(g) Routine physical examinations primarily for insurance, licensing, school, sports, employment, as well as other third-party physicals.

(h) Dental care, including but not limited to treatment on or to the teeth, extraction of teeth, repair of injured teeth, general dental services, treatment of dental abscesses or granulomas, treatment of gingival tissues (other than for tumors), dental examinations, mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service customarily provided by a dentist, except as otherwise specifically set forth elsewhere in the EOC. In addition, treatment to the gums and treatment of pain or infection known or thought to be due to dental cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthoses or protheses are not covered benefits.

(i) Services for the treatment of temporomandibular joint syndrome or dysfunction are not covered where the services are recognized dental procedures. For purposes of this EOC, "recognized dental procedures" include, but are not limited to, the extraction of teeth, the application of orthodontic devices and splints, and services rendered by a licensed dentist or doctor of oral surgery as opposed to a Physician. Where the service is not a recognized dental procedure, benefits will be provided if Medically Necessary, ordered by the Member's Primary Care Physician, and authorized by HHP pursuant to the UM/QA Protocols. Benefits for the treatment of temporomandibular joint syndrome are further limited to the lesser of (a) fifty percent of the billed charges, or (b) $2,500.00.

(j) Custodial, domiciliary care or homemaker services as well as the cost of care rendered by an individual related to, or a part of, Member's family.

(k) Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or nursing home, or any similar institution, regardless of how denominated.

(l) Non-medical services, acupuncture, pain therapy and treatment for the removal of varicose veins, except as otherwise specifically set forth in the EOC.

(m) Long-term physical therapy and long-term rehabilitative services.

(n) Immunizations for travel.

(o) Personal, beautification, or comfort items for inpatients in a Hospital or Skilled Nursing Facility.

(p) Private duty nursing and private rooms in an inpatient setting, unless Medically Necessary, ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(q) Durable medical equipment as well as related supplies and consumables including, but not limited to, oxygen, dressings, ostomy supplies, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, heating pads, personal care or beautification items, warning and monitoring devices (except for infants suffering from recurrent apnea) and any other primarily non-medical equipment, except as otherwise specifically set forth elsewhere in the EOC.

(r) Prosthetic and orthopedic devices, except as otherwise specifically set forth elsewhere in the EOC.

(s) Hearing aids.

(t) Birth control drugs and devices including, but not limited to, IUDs, except as set forth in a Pharmacy Rider to Attachment C.

(u) Psychological services, services or treatment of mental retardation, Downs syndrome, autistic children or other mental health services, except as otherwise specifically set forth elsewhere in the EOC, as well as psychological and psychometric diagnostic testing, evaluation services, and treatment for developmental delay, learning disability, hyperactivity and attention deficit disorder (except initial diagnosis received at the member's PCP only for identification for medication purposes), or any testing or treatment which is the obligation of the school district to provide as mandated by state or federal law.

(v) Care or treatment of chronic marital or family problems; social, occupational, religious, or other social mal-adjustments; chronic behavior disorders; or chronic situational reactions.

(w) Prescription Drugs, including insulin and growth hormone, except as otherwise specifically set forth in Sections A 1 and B of this Attachment A or in a Pharmacy Rider to Attachment C.. Over-the-counter drugs and medicines, including insulin, and other substances not requiring a prescription even if ordered by a Participating Physician via a prescription, drugs consumed in a Physician's office, if other than immunizations, allergy serum, and chemotherapy drugs, except as otherwise provided in a Pharmacy Rider to Attachment C.

(x) Physician services, supplies and equipment relating to the administration or monitoring of Prescription Drugs unless the Prescription Drug is a covered benefit under Sections A 1 or B of this Attachment A or a Pharmacy Rider to Attachment C.

(y) Experimental and investigational drugs, including drugs labeled "Caution - Limited by Federal law to investigational use", as well as drugs either not approved by the Federal Drug Administration as "safe and effective" or, if so approved, which are intended to treat a medical condition for which the U.S. Food and Drug Administration (FDA) has not specifically approved its use, whether used on an inpatient or outpatient basis.

(z) Ecological or environmental medicine including, but not limited to, use of chelation or chelation therapy; orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for such treatment; electro-diagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; acupuncture; replacement of metal dental fillings; laetrile; and gerovital.

(aa) Cosmetics, dietary supplements, vitamins, diet pills, health or beauty aids, Vitamin B-12 injections (except for pernicious anemia), antihemophilic factors, including TPA, acne preparations, laxatives, except as otherwise provided above or elsewhere in this EOC.

(bb) Special formulas, food supplements or special diets including, but not limited to, Total Parental Nutrition (TPN) (except for Acute episodes where Medically Necessary, prescribed by Member's Primary Care Physician and authorized by HHP pursuant to its UM\QA Protocols.)

(cc) All experimental and/or investigational medical, surgical, or other health care procedures as set forth in Part I(G) of the EOC and all transplants, except as otherwise provided above or elsewhere in this EOC.

(dd) Services and costs associated with organ donors where the Member acts as the donor.

(ee) Ambulance service, unless Medically Necessary.

(ff) Care for military service-connected disabilities and conditions for which the Member is legally entitled to receive and for which facilities are reasonably accessible to the Member.

(gg) Care for conditions that federal, state or local law requires be treated in a public facility and care provided under federally or state funded health care programs, except the Medicaid Program, care required by a public entity, as well as care for which there would not normally be a charge.

(hh) Treatment for alcohol or drug abuse, including detoxification services, except as provided in Section A(16) of this Attachment A.

(ii) Sleep therapy (except for central or obstructive apnea when Medically Necessary, ordered by Member's Primary Care Physician, and authorized by HHP pursuant to its UM\QA Protocols), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis.

(jj) Non-newborn circumcisions, unless Medically Necessary.

(kk) Amniocentesis except when done in the last trimester for the purpose of determining fetal lung maturity, in the first 16 weeks for genetic testing, the need for fetal therapy, or to determine a Medically Necessary intervention for the mother when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(ll) Non-symptomatic foot care such as the removal of warts (except planters warts), corns or callouses and including, but not limited to, podiatric treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain.

(mm) Court-ordered treatment or hospitalization, unless otherwise covered by the EOC and determined to be medically necessary by HHP.

(nn) Kidney dialysis or artificial kidney treatments when covered by the Medicare Program or other federal or state programs, other than the Medicaid Program.

(oo) Services for the treatment of suicide, attempted suicide, or intentionally self-inflicted injury, whether the Member is sane or insane, including use of illegal and/or controlled substances, e.g., cocaine, valium.

(pp) Any injury sustained in the commission of a criminal offense.

(qq) Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation and employment counseling.

(rr) Ophthalmological services provided in connection with the testing of visual acuity for the fitting for eye glasses or contact lenses, except as set forth in Section A 1 of this Attachment A. The furnishing or replacing of eye glasses or contact lenses shall not be a benefit, except coverage for the first pair of eye glasses and/or contact lenses following cataract surgery. Radial keratotomy is not covered.

(ss) Charges for care or services provided before the effective date or after the termination of coverage under this EOC.

(tt) Any services or supplies not specifically listed in this EOC as covered benefits, services, or supplies.

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HOSPITAL HEALTH PLAN, INC.
GROUP MEDICAL AND HOSPITAL SERVICE

EVIDENCE OF COVERAGE

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HOSPITAL HEALTH PLAN, INC.
GROUP MEDICAL AND HOSPITAL SERVICE
EVIDENCE OF COVERAGE
PART I. DEFINITIONS

A. **"Acute"** means an illness or injury of a short duration and, generally indicated by a sudden onset and/or infrequent occurrence in which illness or injury is not always present. Acute conditions may become Chronic conditions over time.

B. **"Chronic"** means an illness or injury that is, or is expected to be, of a long duration, i.e., six (6) months or longer, and/or frequent recurrences and is always present to a greater or lesser degree. Chronic conditions may have Acute episodes.

C. **"Copayment"** is the amount of payment indicated in the Schedule of Benefits which is due and payable by the Member to a provider of care upon receipt of certain Covered Services.

D. **"Covered Services"** as described below, are those benefits, services, and supplies which HHP must provide or arrange for while you are a Member.

E. **"Emergency"** means a sudden and unexpected onset of a condition requiring medical or surgical care which the Member secures after the onset of such conditions and in the absence of such care the Member could reasonably be expected to suffer serious bodily injury or death. Heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other Acute conditions as HHP shall determine are Emergencies.

The need for pregnancy-related medical services by a Member travelling outside the Service Area during the third-trimester of pregnancy will not be deemed an Emergency.

F. **"Exclusion"** is an item or service which is not a covered benefit under this Evidence of Coverage (the "EOC"). (See Attachment A, Limitations and Exclusions, Part H.)

G. **"Experimental or Investigational Procedures and Items"** are items and procedures, as well as their related services and supplies, determined not to be generally accepted by the medical community in HHP's Service Area. When making a determination as to whether a service is experimental or investigational, HHP will rely upon the prevailing standards in the Service Area's medical community as it shall determine in the exercise of its discretion. If there are no prevailing standards, then HHP shall use Medicare guidelines or determinations already made by Medicare, unless otherwise specifically excluded in the EOC.

H. **"Family Dependents"** are members of the Subscriber's family who meet the eligibility requirements of this policy set forth in Part II and have been enrolled by the Subscriber.

I. **"Grace Period"** means that if any required premium is not paid on or before the date it is due, it may be paid within 30 days of the due date. During the Grace Period, coverage will stay in effect.

J. **"Group"** means the employer or other party that has entered into a Group Enrollment Contract with HHP under which HHP will arrange and administer health services for eligible members of the Group who enroll.

K. **"Group Enrollment Contract"** means the agreement between HHP and Group under which HHP coverage for Subscribers and their Family Dependents is chosen.

L. **"Group Open Enrollment Period"** means those periods of time established by Group and HHP from time-to-time pursuant to the Group Enrollment Contract but no less frequently than once in any 12 consecutive months during which eligible persons who have not previously enrolled with HHP may do so.

M. **"HHP"** means Hospital Health Plan, Inc., a Nevada corporation licensed by the Nevada Department of Insurance under Chapter 695C of the Nevada Insurance Code ("Nevada HMO Act") and is responsible to arrange the health care services set forth below.

N. **"Home Health Agency"** is an organization licensed by the State which has entered into an agreement with HHP to render home health services to Members, as set forth in Section A(4) of Attachment A.

O. **"Hospital"** is a legally operated facility defined as an Acute-care or tertiary hospital and an institution licensed by the State and approved by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), the American Osteopathic Association ("AOA") or by the Medicare program.

P. **"Hospital Services"** (except as limited or excluded herein) are those Acute-care and tertiary services furnished and billed by a Hospital and/or Skilled Nursing Facility which are ordered by a Member's Primary Care Physician, authorized pursuant to HHP Utilization Management and Quality Assurance ("UM/QA"), and set forth or referenced in Part IV and V.

Q. **"Medical Director"** means a Physician designated by HHP to monitor and review the utilization and quality of health services provided to Members.

R. **"Medical Group"** means any group or association of physicians that has contracted with HHP to provide or arrange for services to Members. **HHP does not guarantee the continued availability of any particular Medical Group.**

S. **"Medically Necessary"** means the use of services or supplies as provided by a Hospital, Skilled Nursing Facility, Physician or other health care provider required to identify or treat a Member's illness or injury and which, as determined by HHP, are:

1. Consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury;
2. Appropriate with regard to standards of medical practice within the Service Area's medical community;
3. Not primarily for the convenience of the Member, Member's family, Member's Physician, Hospital, or other health care provider; and
4. The most appropriate supply or level of service which can be safely provided to the Member.

The fact that a service is prescribed or recommended by a Physician or other health care provider does not necessarily mean that the service is Medically Necessary or authorized by HHP.

T. **"Medicare"** means Title XVIII of the Social Security Act, as amended.

U. **"Member"** shall mean both Subscriber and Family Dependents.

V. **"Out-of-Service-Area"** are those services provided outside the Service Area and are limited to Emergency Services or Urgently needed services only. Services outside the Service Area that are ordered by a Primary Care Physician and authorized pursuant to UM/QA Protocols are fully covered.

W. **"Participating Physician"** is a Physician who, at the time of providing or authorizing services to a Member, is associated with a Medical Group or has contracted with HHP to provide health care services to Members. A Participating Physician's agreement with HHP or association with a Medical Group, or a Medical Group's agreement with HHP, may terminate and a Member will be required to utilize another Participating Physician, at HHP's discretion.

X. **"Participating Provider"** is a Physician, Medical Group, Hospital, Skilled Nursing Facility, Home Health Agency or any other duly licensed institution or health professional under contract with HHP to provide Covered Services to Members. A list of Participating Physicians and Hospitals will be provided to the Subscriber by HHP at the time this EOC is delivered. A Participating Provider's agreement with HHP or association with a Medical Group may terminate and a Member may be required to utilize another Participating Provider.

Y. "Physician" is a duly licensed (1) doctor of medicine or osteopathy. (2) Physician also means doctors of dentistry, podiatry, psychology, chiropractry, chiropodists and oriental medicine, as well as, marriage and family counselors, clinical social workers, opticians, nurse practitioners, audiologists, physical therapists, speech pathologists, occupational therapists and any other practitioner when they are duly licensed by the jurisdiction where they are providing services, operating within the scope of their license, providing a service for which benefits are specified by this EOC, and when benefits would be payable if the services were provided by a Physician as set forth in sub-part (1) of this Part (Y).

Z. **"Prescription Drug"** means a drug, medicine or supply that bears the legend in its packaging "CAUTION: FEDERAL (U.S.A.) LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION."

AA. **"Primary Care Physician"** means a Participating Preferred Physician who has primary responsibility for providing, arranging and coordinating all aspects of a Member's health care. A Member shall select a Primary Care Physician (i.e., a general or family practitioner, internist or pediatrician, or such other Physician specialty as may be designated by HHP) from HHP's current list of Primary Care Physicians.

BB. **"Resident"** means an individual who actually lives and dwells at a specific location within HHP's Service Area for nine (9) or more months each calendar year, but may include Temporary Absences from the Service Area. Family Dependents will be exempt from this definition when enrolled as a student, as further provided in Part II, Eligibility and Enrollment, of this EOC. Merely having the intent to reside at a specific location is insufficient to establish a residence, unless exempted by HHP in its sole discretion.

CC. **"Service Area"** means the area within which HHP has received regulatory approval to operate as set forth in Attachment D.

DD. **"Short Term"** means therapy that is limited to treatment for conditions which are subject to significant clinical improvement within sixty (60) days of the initial commencement of the therapy.

EE. **"Skilled Nursing Care"** means services that can only be performed by, or under the supervision of, licensed nursing personnel.

FF. **"Skilled Nursing Facility"** is a facility which is duly licensed by the State which provides inpatient skilled nursing care, rehabilitation services or other related health services.

GG. **"Specialty Care Physician"** is a Physician who provides certain specialty medical care upon referral by Member's Primary Care physician and authorized by HHP pursuant to its UM/QA Protocols.

HH. **"Temporary Absence"** means an absence from the Service Area of more than thirty (30) minutes travel time, but not more than ninety (90) days.

II. **"Subscriber"** is a person who meets all applicable eligibility requirements of Part II, and whose Enrollment Form has been accepted by HHP in accordance with the enrollment requirements of this EOC.

JJ. **"Tertiary Care"** means the highest and/or the most complex level of care for the treatment of a particular medical condition and not generally available in a community hospital.

KK. **"Urgent Care Services or Urgently Needed Services"** mean benefits covered under this EOC for a sudden illness or injury requiring treatment on a same-day basis; this sudden illness or injury would normally be treated in a physician's office but because this sudden illness or injury occurs after or before normal physician's office hours, is unforeseen and/or occurs while the member is out of the HHP service area, treatment is obtained at an URGENT CARE site. Routine or follow-up care will <u>not</u> be considered urgent care.

The need for pregnancy-related medical services by a Member outside the service area during the third-trimester of pregnancy will not be considered an unforeseen event.

LL. **"UM/QA Protocols"** mean those procedures adopted by HHP to assure that the services provided to Members are Medically Necessary and that preventive, Acute and Tertiary Care is provided to Members on the most cost effective basis available consistent with the provision of quality care.

MM. **"Usual and Reasonable Charge"** is the amount charged or the amount HHP determines to be the prevailing charge, whichever is less, for a particular health service in the geographical area in which it is performed.

PART II. ELIGIBILITY AND ENROLLMENT

A. Who is Eligible for Coverage.

1. Subscriber. To be eligible to enroll as a Subscriber, a person must:
   (a) be a Resident of the Service Area (a Temporary Absence from the Service Area is permitted without loss of eligibility);
   (b) be an employee of the Group who is entitled on his/own behalf to participate in the medical and hospital benefits arranged by Group, including satisfaction of any probationary or waiting period established by Group;
   (c) complete and execute all enrollment forms and such other documents as required by HHP; and
   (d) pay any and all premium which is applicable.

2. Eligible Family Dependents. To be eligible to enroll as a Family Member, a person must be listed on the enrollment form completed by the Subscriber, meet all dependent eligibility criteria established by the Group, be a Resident of the Service Area, and be:
   (a) The Subscriber's lawful spouse; or
   (b) Any unmarried child (limited to a step-child, legally adopted child as well as a natural child) of either Subscriber or Subscriber's spouse, who is under age nineteen (19), is a Resident of the Service Area (except as provided in sub-part (c) of Part II(A)(2)), and is a dependent of the Subscriber as defined by the United States Internal Revenue Code or must be provided with coverage due to court order (i.e. divorce) subject to the balance of this Part II.
   (c) Any unmarried child as defined in subsection (b), above, who is between nineteen (19) and twenty-five (25) years of age provided the child is able to provide documentation acceptable to HHP that he/she is a full-time student in an accredited educational institution, i.e., a preparatory school or an educational institution which is eligible for payment of benefits under the Veterans Administration Program, but excluding church-related preparatory programs as that institution defines a full-time student. Actual residency in the Service Area is not required. Coverage outside the Service area, however, is limited to Emergency and Urgently Needed Services only. If a Family Dependent is no longer a full-time student and proper notice is not provided to HHP pursuant to Section II(E), HHP shall have the right to retroactively terminate coverage on the last day of the month full-time student status actually ceased and to recover an amount from Subscriber and/or Family Dependent equal to the Usual and Reasonable Charge for services provided subsequent to that date.
   (d) Any unmarried child who is and continues to be **both** (1) incapable of self-sustaining employment by reason of mental or physical handicap, **and** (2) chiefly dependent upon the Subscriber for economic support and maintenance, provided proof of such incapacity and dependency is furnished to HHP by Subscriber within thirty-one (31) days of the child's attainment of the applicable limiting age. HHP's determination of eligibility shall be conclusive.
   (e) Newborn or newly acquired child of the Subscriber or the Subscriber's spouse have coverage from the moment of birth or acquisition, subject to all other applicable provisions of this EOC. If the child is adopted or placed for adoption, then coverage shall commence the date the adoption becomes effective pursuant to Nevada law or from the moment of placement in the Subscriber's home subject to certification of such placement by the public or private agency making that placement.

   Coverage of the newborn or newly acquired child (whether or not adopted) shall automatically cease upon the passage of thirty-one (31) days from birth or acquisition unless the child is enrolled in HHP and all applicable premiums paid within the above time frame or, in the case of a child placed for adoption, upon the date the adoption proceedings are terminated as certified by the public or private agency making the placement.

(f) Neither a foster child, a legal ward, a child who has been placed in the Subscriber's home (except those placed for adoption), a grandchild of a Subscriber or Subscriber's spouse, an emancipated minor under state law, or any other person not defined in Part II(A)(2)(a) through (e), above, is a Family Dependent for purposes of this EOC (Except those legal wards, permanently placed in the subscriber's home by court order).

B. Enrollment.

1. Initial Enrollment. Each eligible employee of the Group during the initial Group Enrollment Period shall be entitled to apply for coverage for himself or herself and eligible Family Dependents who must be listed on the enrollment form provided by HHP.

2. Newly Eligible Employees. Each new employee of the Group entering employment subsequent to the Group's initial enrollment effective date shall be permitted to apply for coverage for himself or herself and eligible Family Dependents, within thirty (30) days of becoming eligible, subject to the enrollment regulations in effect with the Group.

3. Newly Eligible Family Dependents. Any person attaining qualification as a Family Dependent may be enrolled by the Subscriber by completing and submitting to HHP a signed enrollment form within thirty (30) days of qualifying as a Family Dependent.

4. Limitation. Persons initially or newly eligible for enrollment who do not enroll within thirty (30) days of eligibility or who have previously waived coverage, may only be enrolled during a subsequent Group Open Enrollment Period or by Evidence of Insurability (EOI), whichever is applicable under the Group Subscription Agreement.

C. Enrollment Effective Date.

Subject to the payment of applicable premium payments by the Group for the individual, HHP's receipt and acceptance of an enrollment form on behalf of each prospective Member, and the provisions of this EOC coverage under this EOC shall become effective the day on which the above steps are completed, except as otherwise provided in the Group Enrollment Contract.

Coverage for adopted newborns will be from the date the adoption becomes effective pursuant to Nevada law or from the moment of placement in the Subscriber's home subject to certification of such placement by the public or private agency making that placement.
Coverage for all other newborns will begin at the moment of birth and shall automatically cease upon the passage of thirty one (31) days from birth unless the newborn is enrolled in HHP and all applicable premiums paid within the above time-frame.

D. Delivery of Documents.

HHP will provide a copy of this EOC to each Subscriber upon enrollment.

E. Notice of Ineligibility.

It shall be the Subscriber's responsibility to notify Group of any changes which will affect Subscriber's eligibility or that of Family Dependents under this EOC.

F. Rules of Eligibility.

No person is eligible to re-enroll hereunder who has had coverage terminated under Part III(A) (1-2). No individual will be refused coverage due to his/her race, color, economic status, creed, marital status, age (except as provided in Part II(A), sex or national origin. No Member's coverage will be terminated or renewal refused due to his/her age, health status (except as provided in Part II(A), economic status, health care needs, or prospective health care costs.

PART III. TERMINATION OF MEMBER'S COVERAGE

A. Termination.

Except as expressly provided in this EOC, and subject to the provisions of Parts X and XI, coverage under this EOC for a Member will terminate or be cancelled as follows:

1. Cancellation

(a) In the event any Member fails to pay, have paid on his account or for his benefit, or make satisfactory arrangements to pay any Copayment respecting such Member, coverage shall terminate for the Member upon thirty (30) days written notice to the Member.

(b) If the Group enrollment Contract is terminated, a Member's coverage under this EOC shall also be canceled on the effective date of the termination of the Group enrollment Contract.

2. Termination for Cause

(a) If the Member permits the use of his or her card for any other person, or uses another person's card, the card may be retained by HHP and coverage of the Member shall terminate upon thirty (30) days written notice to the Member. Subscriber (and Member if different) shall be liable to HHP for all costs incurred as a result of the misuse of the identification card.

(b) If Participating Physicians are unable to establish or maintain a satisfactory physician-patient relationship with a Member, coverage of the Member may be terminated upon thirty (30) days written notice to the Member. Examples of unsatisfactory physician-patient relationship include, but are not limited to, abusive or disruptive behavior in a Physician's office, repeated refusals by the Member to accept procedures or treatment recommended by a Participating Physician, and Member's securing services in a manner that impairs the ability of the Primary Care Physician to coordinate Member's care.

(c) If incorrect or incomplete information was furnished to HHP which constitutes a material misrepresentation, then the coverage of the Member who either furnished such information and/or on whose behalf such information was furnished may, at HHP's sole discretion, either be terminated immediately, upon thirty (30) days notice, or be voided retroactive to the effective date of coverage. In addition, the Subscriber (and Member if different) shall be responsible for all costs incurred by HHP as a result of the misrepresentation.

(d) If a Member fails to cooperate in HHP's administration of the Double Coverage, Coordination of Benefits and Subrogation provisions set forth in Parts VI, VIII, and IX, respectively, then the coverage of such Member may be terminated upon thirty (30) days written notice by HHP.

B. Reinstatement.

A Member shall not be reinstated automatically if coverage is terminated; reapplication with Evidence of Insurability is required. At HHP's sole discretion, this requirement may be waived.

C. Refunds.

If the coverage of a Member is terminated, contract charges received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded within thirty (30) days, less any medical costs incurred by HHP for that period, and neither HHP nor Participating Providers shall have any further liability to such Member under this EOC. Any claims for refunds must be made within ninety (90) days from the effective date of termination of the Member's coverage or otherwise payment of such claims shall be deemed waived.

PART IV. COVERED SERVICES AND BENEFITS

Each Member shall select or have selected on his/her behalf a Primary Care Physician through whom certain covered primary medical services shall be provided and who will coordinate the other Covered Services to be received by the Member from other Participating Providers. If a Member receives services through a Physician or health care provider other than his/her Primary Care Physician and such services were not ordered by his/her Primary Care Physician and authorized by HHP, if applicable, pursuant to the UM/QA Protocols, those services will not be covered except in a true Emergency or for Urgently Needed Services. Services provided by a non-participating provider that are ordered by the member's Primary Care Physician and are authorized by HHP prior to the date of the service(s) are considered a covered benefit subject to the conditions of this EOC and Attachments A, B and C. Members may change their Primary Care Physician by submitting the required forms in accordance with HHP procedures.

A Member shall be entitled to receive the medical care and services of Physicians and other Participating Providers including medical, surgical, diagnostic, therapeutic and preventive services, as set forth in Attachment A, which are generally and customarily provided in the Service Area, which are determined to be Medically Necessary AND ARE PERFORMED, PRESCRIBED, DIRECTED OR ORDERED BY A MEMBER'S PRIMARY CARE PHYSICIAN AND AUTHORIZED BY HHP PURSUANT TO THE UM/QA PROTOCOLS, IF APPLICABLE.

When two (2) or more courses of treatment are medically equivalent or substantially medically equivalent, as determined by HHP, HHP has the right, at its discretion, to substitute less costly services or benefits for those which would otherwise be covered or available under the EOC, whether or not such less costly benefits would or would not otherwise be covered. This means that if both inpatient care in a skilled nursing facility and nursing care in the home on a part time intermittent basis would be medically appropriate, and inpatient care would be less costly, HHP can limit coverage to inpatient care. Moreover, HHP can limit coverage to inpatient care even if it means extending the quantity of inpatient benefit beyond that provided in this EOC.

The fact that a Participating Physician or Provider may prescribe, order, recommend or approve a service or supply does not, of itself, make it a Covered Service or Medically Necessary unless such prescription, order, recommendation, or approval otherwise complies with the HHP's UM/QA Protocols, the definition of Medically Necessary in Part I(S), even though it is not specifically listed as an exclusion, and is expressly provided for herein.

Member shall not obtain a vested interest in any Covered Service merely by virtue of the fact that the Member has begun to receive a Covered Service. HHP may amend or terminate this EOC according to the Group Enrollment Contract and Member shall not have a vested interest in continued coverage under this EOC or any Covered Service, except as set forth in Part XI.

HHP WILL NOT COVER SERVICES RENDERED TO A MEMBER IF A MEMBER CONSULTS A PHYSICIAN OR HEALTH PROFESSIONAL WITHOUT A PRIOR REFERRAL FROM HIS/HER PRIMARY CARE PHYSICIAN AND PRIOR AUTHORIZATION BY HHP PURSUANT TO THE UM/QA PROTOCOLS, IF APPLICABLE, EXCEPT IN AN EMERGENCY OR FOR URGENTLY NEEDED SERVICES.

A MEMBER WILL BE LIABLE FOR CERTAIN COPAYMENTS TO PROVIDERS OF SERVICES FOR SPECIFIED SERVICES AS SET FORTH IN THE "SCHEDULE OF COPAYMENTS" ANNEXED AS ATTACHMENT C.

V. UTILIZATION MANAGEMENT PROGRAM

The Managed Care/Utilization Management Program is intended to assure the most appropriate level and amount of care at the least cost.

A. Scope of program.

The Utilization Management Program applies to all Covered Services other than those provided by a Member's Primary Care Physician. Referral from Member's Primary Care Physician and authorized by HHP is required for all referrals to other Participating Physicians and follow-up visits. Covered Services subject to this Utilization Management Program include, but are not limited to, the following:

1. All inpatient stays and extensions whether in a Hospital, Skilled Nursing Facility, mental health facility, or drug and alcohol detoxification facility;
2. Home Health Care;
3. Hospice Care;
4. Short-Term Rehabilitative Services whether on an inpatient or outpatient basis;
5. Mental Health and Substance Abuse Services;
6. Prosthetic Devices;
7. Surgical services whether performed on an inpatient or outpatient basis;
8. All Specialty Physician referrals;
9. Prescription Drugs prescribed for a Member during an inpatient stay (outpatient Prescription Drugs are not a Covered Service unless otherwise provided in a Pharmacy Rider to the EOC); and
10. Services of all non-Participating Providers except in the case of an Emergency or Urgently Needed Services.

It is the obligation of the Member to comply and cooperate with the Managed Care/Utilization Management Program.

B. The Program.

The Managed Care\Utilization Management Program includes, but is not limited to, a consideration of the following elements:

1. Whether the recommended level and/or site of care is Medically Necessary;
2. Whether the recommended level and/or site of care is medically appropriate and cost effective in light of the available alternatives;
3. Whether the duration or treatment is Medically Necessary, appropriate and efficacious.

HHP will utilize a number of steps in these determinations including, but not limited to: pre-admission review; admission review; continued stay review; and case management.

C. Appeals.

In addition to the Grievance Procedures referenced in Part XII(J), below, HHP maintains a rapid appeals system to reconsider denials of certification for inpatient stays based upon lack of Medical Necessity. An appeal must be filed by a Member, or a personal representative, including a Physician, within 24 hours of receipt of an adverse determination. A decision will be issued within 72 hours. During the appeal, the course of care or proposed care will not be interrupted and, if the appeal prevails, the care will be covered, subject to the other provisions of the EOC. If the appeal does not prevail, the Member or the Subscriber in the case of an underage Member will be financially liable for that care and Member and/or Subscriber agree to pay for such care as a condition of receiving the disputed care. Should a Member or personal representative desire to appeal a denial he can do so by calling Member Services. If a Member fails to pursue such an appeal, that will terminate any obligations that HHP may have to him\her with respect to that care. Notwithstanding the above, the Member may still pursue the Grievance Procedure referenced in Attachment B.

COMPLIANCE BY THE MEMBER WITH THE MANAGED CARE/UTILIZATION MANAGEMENT PROGRAM IS MANDATORY. FAILURE TO COMPLY WILL RESULT IN THE LOSS OF BENEFITS UNDER THIS EOC.

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PART VI. DOUBLE COVERAGE

A. Workers' Compensation and Automobile Liability Insurance.

The benefits under this EOC are not designed to duplicate any benefit to which such Members are eligible under Workers' Compensation or third-party Automobile Liability Insurance. All sums payable pursuant to Workers' Compensation or third-party Automobile Liability Insurance for services provided or arranged for Members are payable to and retained by HHP. It is also understood that coverage under this EOC is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation and Automobile Liability Insurance. A Member's failure to pursue his/her Worker's Compensation rights or the waiver of those rights shall be considered a violation of this provision.

B. Medicare.

Except as otherwise provided by applicable federal law, the benefits under this EOC for Members age sixty-five (65) and older, or Members otherwise covered by Medicare, do not duplicate any benefit to which such Members are eligible under the Medicare Act, including Part B of such Act, except Medicare copayments and deductibles. Where Medicare is the primary payor, all sums payable pursuant to the Medicare program for services provided under this EOC are payable to and retained by HHP, or as otherwise directed by HHP.

C. Members' Cooperation.

Each Member shall complete and submit to HHP such consents, releases, assignments and other documents as may be requested by HHP in order to obtain or assure reimbursement where HHP is the secondary payer under this Part. Any Member who fails to so cooperate (including a Member who enrolls in HHP on or after January 1, 1993 and fails to enroll under Part B of the Medicare Program as soon as possible where Medicare is the primary payor) will be responsible for the Usual and Reasonable Fee for services subject to this Part VI, any legal costs incurred by HHP to enforce its rights under this Part, and may be terminated in accordance with Part III(A)(2)(d).

PART VII. RELATIONSHIP OF PARTIES

A. Independent Contractors

THE RELATIONSHIP BETWEEN HHP AND CONTRACTED PROVIDERS IS THAT OF AN INDEPENDENT CONTRACTOR RELATIONSHIP; PROVIDERS ARE NOT AGENTS OR EMPLOYEES OF HHP, NOR IS HHP, OR ANY EMPLOYEE OF HHP, AN EMPLOYEE OR AGENT OF THE PROVIDERS. HHP SHALL NOT BE LIABLE FOR ANY CLAIM OR DEMAND ON ACCOUNT OF DAMAGES ARISING OUT OF, OR IN ANY MANNER CONNECTED WITH, ANY INJURIES SUFFERED BY THE MEMBER WHILE RECEIVING CARE FROM ANY PROVIDER OR IN ANY PROVIDER'S FACILITIES.

B. Provider/Patient Relationship

Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all health services. Certain Members may, for personal reasons, refuse to accept procedures or treatment afforded or recommended by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of their provider-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all necessary and appropriate medical care in a manner compatible with a Provider's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure after the Provider has used his/her best efforts to elicit the Member's cooperation, and the Provider believes that no professionally acceptable alternative exists, such Member shall be so advised. In such case, neither HHP, nor any Provider, shall have any further responsibility to pay for, provide, or arrange care for the condition under treatment or related ancillary care related to such refusal. The continued refusal by the Member to follow the recommended treatment or procedures(s) will result in no benefits being paid.

HHP SHALL NOT INTERVENE WITH THE PROVISION OF MEDICAL SERVICES, IT BEING UNDERSTOOD THAT THE TRADITIONAL RELATIONSHIP BETWEEN PROVIDER AND PATIENT WILL BE MAINTAINED. THUS, A BENEFIT DETERMINATION BY HHP THAT A PARTICULAR COURSE OF MEDICAL TREATMENT IS NOT A COVERED SERVICE OR IS INCONSISTENT WITH UM/QA PROTOCOLS AND, THUS, NOT AVAILABLE UNDER HHP COVERAGE, SHALL NOT BE DEEMED BY MEMBERS TO BE A MEDICAL DETERMINATION BY HHP.

PART VIII. COORDINATION OF BENEFITS

This Part tells you how other health benefit plans and/or insurances you may have affect your coverage under this EOC.

A. The Purpose of COB

Many people have health coverage provided by more than one plan at the same time. Each plan has rules for COB in the event of double coverage to prevent the total amount of all their benefit payments from exceeding the cost of the Covered Services. This COB provision helps to contain the cost of health care coverage.

B. Benefits Subject to COB

All of the health benefits provided under this EOC are subject to this Part. The Member agrees to permit HHP to coordinate its obligations under this EOC with payments under any other group health insurance plan that covers the Member.

C. DEFINITIONS

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

1. "Plan" will mean an entity providing group health care benefits or services by any of the following methods:

   (a) Group Insurance or any other arrangement for coverage for individuals whether on an insured or third-party uninsured basis, including but not limited to:
      i. Group hospital indemnity benefits with regard to the amount in excess of thirty dollars ($30) per day; and
      ii. Group hospital reimbursement type plans which permit the insured person to elect indemnity benefits at the time of claim.

   (b) Group service plan contracts, group practice, group individual practice and other group prepayment coverage;
   (c) Any group coverage for students which is sponsored by, or provided through, school or other educational institutions, other than accident coverage for grammar school or high school students for which the parent pays the entire premium;
   (d) Any coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefits plans;
   (e) Any group automobile reparations third-party no fault insurance required under any law of a state, but only to the extent of benefits required under such third-party no fault law and only to the extent coordination of benefits is permitted under such third-party no fault law;
   (f) Coverage under a governmental program, including Medicare and Workmen's compensation plans.

2. 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.

3. "Allowable Expense" means the Eligible Medica' 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 deemed to be an Allowable Expense and a benefit paid.

4. "Claim Determination Period" means the Calendar Year.

5. "Primary Plan" means a Plan which, in accordance with the rules regarding the order of benefits determination, provides benefits or benefit payments without considering any other plan.

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

D. When COB Applies.

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

E. Determination Rules.

The rules establishing the order of benefit determination are:

1. Non-dependent/Dependent. The benefits of the Plan which covers the person as a Subscriber (that is, other than as a Dependent) are primary to those of the Plan which covers the person as a Dependent.

2. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (c) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

   (a) the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year;
   (b) but, if both parents have the same birthday, the Plan which covers a parent longer is primary; and
   (c) 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.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   (a) first, the Plan of the parent with custody of the child;
   (b) then, the Plan of the spouse (stepparent) of the parent with custody of the child;
   (c) finally, the Plan of the parent not having custody of the child.

   Notwithstanding a, b and c above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

4. Active/Inactive Employee. A Plan which covers a person as an employee who is neither laid off not retired (or that employee's dependents) is primary to a Plan which covers that person as a laid off or retired employee (or that employee'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 '4' is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the Plan which covered the Subscriber longer is primary to the Plan which covered that person for the shorter time period. Two consecutive Plans shall be treated as one if:
   (a) the claimant was eligible under the second Plan within twenty-four (24) hours after the termination of the first Plan; and if
   (b) 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
   (c) there was a change from one type of Plan to another (e.g., single employer to multiple employer Plan).

6. COB/No COB Provision. If another Plan does not contain a provision coordinating its benefits with those of this Plan, then the benefits of such other Plan shall be determined before the benefits of this Plan.

F. How COB Works.

Plans use COB to decide which health care 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.

G. Right to Receive and Release Information.

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

1. release to any person, insurance company or organization, the necessary claim information;
2. receive from any person, insurance company or organization, the necessary claim information;
3. require any person claiming benefits under this EOC to give HHP any information needed by HHP to coordinate those benefits.

H. Right to Recover Payment.

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

1. any persons to or for whom such payments were made;
2. any group insurance companies or service plans; and
3. any other organizations.

I. Member's Cooperation.

Any Member who fails to cooperate in HHP's administration of this Part will be responsible for the Usual and Reasonable Charge for services subject to this Part VIII, plus legal expenses, if awarded by a court or a dispute resolution entity, incurred by HHP to enforce its rights under this Part, and may be terminated in accordance with Part III(A)(2)(d).

PART IX. SUBROGATION

If a Member is injured or becomes ill through the act of a third party, HHP shall provide care for such injury or sickness. Acceptance of such services will constitute consent to the provisions of this Part.

In the event of any payments for benefits provided to a Member under this EOC, HHP, to the extent of such payment, shall be subrogated to all rights of recovery such Member has against any person or organization and HHP shall be entitled to receive from any such recovery an amount up to the Usual and Reasonable Charges for the services provided by HHP. Member shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to HHP.

Any such right of subrogation or reimbursement provided to HHP under this EOC shall not apply or shall be limited to the extent that Nevada statutes or the courts of Nevada eliminate or restrict such rights.

HHP shall have a lien on all funds received by Member up to the Usual and Reasonable Charge for the services and supplies provided and to be provided to Member. HHP may give notice of that lien to any party who may have contributed to the loss.

If HHP so decides, it may be subrogated to the Member's rights to the extent of the benefits received under this EOC. This includes HHP's right to bring suit against the third party in the Member's name.

The Member must take such action, furnish such information and assistance, and execute such instruments as HHP may require to facilitate enforcement of its rights under this provision. The Member shall take no action prejudicing the rights and interests of HHP under this provision. Any Member who fails to cooperate in HHP's administration of this Part shall be responsible for the Usual and Reasonable Charges for services subject to this Part IX, any legal costs incurred by HHP to enforce its rights under this Part, and may be terminated in accordance with Part III(A)(2)(d).

PART X. PREMIUM PAYMENTS

A. Monthly Payments.

The first (1st) day of the month is the premium due date. On or before the premium due date, Group or its designated agent shall remit to HHP,on behalf of each Subscriber and his/her Family Dependents,the amount specified in the Group Enrollment Contract.

B. Failure to Render Payments.

Only Members for whom the stipulated premium payment is actually received by HHP shall be entitled to benefits under this EOC and, then, only for the period for which such payment is received. If any required payment on behalf of a Member is not received by the premium due date, and payment is not made within the Grace Period, all rights of such Member will terminate, at the option of HHP, as of the last date for which premium payments have been made. HHP shall not be liable for any health care services incurred by any Member, in the name of HHP, beyond the period for which the premium payment shall have been paid, and HHP shall be entitled to indemnification by the Group, Subscriber and the Member, jointly and severally, for the Usual and Reasonable Charge for all services provided or arranged for Members by HHP during the Grace Period and thereafter.

C. Changes in Rates.

HHP reserves the right to establish a revised schedule of premium payments as provided for in the Group Enrollment Contract. If a change in this EOC is required by law or regulation which increases HHP's risk under this certificate, HHP reserves the right to change the schedule of premium payments retroactive to the effective change in risk upon thirty (30) days written notice to Group.

PART XI. CONVERSION PRIVILEGE, COBRA, NEVADA CONTINUATION OF COVERAGE UNDER CERTAIN GROUP POLICIES, AND CONTINUATION OF COVERAGE: TOTAL DISABILITY

A. Conversion.

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

1. Who May Obtain Conversion Coverage

Only a Subscriber and his/her enrolled Family Dependents leaving a Group, and only a Member who would otherwise cease to be eligible for HHP membership due to ineligibility (see Part II), who has been enrolled under this EOC for three (3) consecutive months, has the right to convert membership to the non-Group conversion program available from HHP at the time of application, without furnishing evidence of insurability. The benefits provided by the conversion coverage will not be as comprehensive as those offered by this EOC. For example, all Copayments may be higher and any Riders attached to this EOC will not be available.

2. Who May Not Obtain Conversion Coverage

A Member is not eligible to convert:

(a) if the Member is eligible for other health coverage within thirty-one (31) days of termination;
(b) if the Member is eligible for Medicare;
(c) if the Group Enrollment Agreement is discontinued in its entirety or with respect to an insured class;
(d) if the Group replaced this EOC with another insured or self-insured health care program within thirty-one (31) days after termination of the Group Enrollment Agreement;
(e) if the Member would be considered overinsured;
(f) if the Member voluntarily terminated his/her coverage under the EOC; or
(g) if the Member does not remain a resident of the Service Area.

3. Overinsurance

A person will be considered Overinsured if:

(a) Such person's insurance under this EOC is replaced by similar Group coverage within thirty-one (31) days of termination; or
(b) The benefits under the conversion policy, combined with Similar Benefits, result in excess insurance based on HHP's underwriting standards for individual policies. Similar Benefits are:
    i. those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital or medical service Subscriber contract, or a medical practice or other prepayment plan, or by any other plan or program;
    ii. those for which the person is eligible, whether or not covered, under any plan or Group coverage on an insured or self-insured basis; or
    iii. those available for the person by, or through, any local, state or federal law.

A Member must apply for conversion and pay any applicable premiums within thirty-one (31) days of the date of ineligibility for coverage under this EOC.

Conversion rights are subject to all terms and conditions as HHP may have in effect as of the date of application for conversion coverage.

HHP or Group will provide, upon request, further details of the conversion coverage.

B. Federal Consolidated Omnibus Reconciliation Act (COBRA)

Employers who employ 20 or more employees and provide health care coverage for their employees are subject to comply with the Continuation of Coverage requirements of COBRA.

1. Qualifying events for Continuation of Coverage for Members covered under this agreement are:

(a) Death of Subscriber.
(b) Termination of Subscriber's employment for reasons other than gross misconduct.
(c) Reduction of Subscriber's working hours resulting in loss of coverage.
(d) Divorce or legal separation of Subscriber from Subscriber's Spouse.
(e) Eligibility of Subscriber for Medicare.
(f) Loss of a Child's dependent status under requirements of the plan.

2. Notice of Continuation of Coverage

(a) The Group must provide written notice, at the time coverage commences under this Agreement, to each Subscriber and Spouse of Subscriber of their right and their dependent Children's right to elect Continuation of Coverage when eligible.
(b) The Group must provide written notice of Continuation of Coverage to the plan administrator (if the plan administrator is not the Group) within 30 days from the date of Subscriber's:
  i. Death, or
  ii. Termination of employment, or
  iii. Reduction of work hours resulting in loss of coverage, or
  iv. Eligibility for Medicare benefits.

(c) The Member must provide notice to the Group (or the plan administrator if different from the Group) of the following:
  i. Member's divorce or legal separation, or
  ii. Member's loss of eligibility as a Dependent Child under this Agreement because of age or marriage.

(d) The Group (itself or by its plan administrator) must provide notice of Continuation of Coverage to the Member within 14 days of the date of receipt of notice of any qualifying event.
(e) The Member must provide notice to the Group (or plan administrator if different from the Group) of the Member's intention to elect Continuation of Coverage within 60 days from the date notice to elect Continuation of Coverage is received from either the Group or the plan administrator.
(f) The Group must provide notice of a Member's election of Continuation of Coverage to HHP together with payment of appropriate subscription charges, within 45 days following, but in no event later than the end of a period of 150 days after the occurrence of a qualifying event, in order for that Member to be entitled to Continuation of Coverage.
(g) The Group must provide notice to the Member, within 180 days before termination of Continuation of Coverage, of the Member's right to elect Conversion Coverage provided under this Agreement.
(h) In no event will HHP be the plan administrator. The term "plan administrator" refers to a person or entity, other than HHP, engaged by the Group to perform, or assist the Group in performing, administrative tasks in connection with the Group's health plan(s). In providing notices and otherwise performing under these provisions for Continuation of Coverage, the Group is not acting as the agent of HHP; but rather, the Group is fulfilling statutory obligations imposed on it by Federal Law and, where applicable, acting as the agent of the Member.

3. Payment of Subscription Charges

The Group is responsible to HHP for the timely payment of subscription charges due for the continuation of any Member's coverage under this Agreement.

4. Commencement of Continuation of Coverage

(a) **Subscriber**

If HHP receives from the Group, timely notice of an election of Continuation of Coverage, together with timely payment of appropriate subscription charges, a Continuation of Coverage period not to exceed 18 months for Subscriber and/or Family Members for whom Continuation of Coverage is elected by the Subscriber, and who were enrolled under this Agreement at the time of the qualifying event, will commence upon:

i. Reduction in Subscriber's working hours resulting in loss of coverage, or
ii. Subscriber's termination from employment for reasons other than gross misconduct.

(b) **Spouse**

If HHP receives from the Group, timely notice of an election of Continuation of Coverage, together with timely payment of appropriate subscription charges, a Continuation of Coverage period not to exceed 36 months for a Spouse and any Dependent Children for whom Continuation of Coverage is elected, and who were enrolled under this Agreement at the time the qualifying event, will commence upon:

i. the death of Subscriber, or
ii. Notice of legal separation, final decree of divorce, annulment or dissolution of marriage between Subscriber and enrolled Spouse, or
iii. Subscriber's eligibility for Medicare.

(c) **Dependent Children**

If HHP receives from the Group, timely notice of an election of Continuation of Coverage, together with timely payment of appropriate subscription charges, a Continuation of Coverage period not to exceed 36 months for Dependent Children enrolled under this Agreement at the time of the qualifying event will commence upon:

i. Loss of eligibility because of age or marriage, or
ii. Any one of the conditions listed under paragraph 4.a or 4.b, above (except when Children of a divorced or legally separated Spouse of a Subscriber remain enrolled as Family Members of that Subscriber).

5. Termination of Continuation of Coverage

(a) **Subscriber**

Continuation of Coverage which commenced under paragraph 4.a, above, for a Subscriber and/or any Family Members of that Subscriber will terminate at the end of the period for which subscription charges have been paid when the first of the following events occurs:

i. A period of 18 months has elapsed, or
ii. This Agreement between the Group and HHP is canceled, or
iii. The required subscription charges for the next period are not paid, or
iv. The Member becomes eligible for Medicare, or
v. The Member becomes covered as an employee under another group health plan (except when the member's new group health plan restricts coverage for a pre-existing condition limitation, then continuation of coverage may continue until the pre-existing condition limitation is satisfied or until another cause for termination of continuation of coverage occurs. The continuation of coverage plan [this EOC] will be secondary in coverage to the member's new group health policy), or
vi. HHP receives written notice of the Member's voluntary cancellation of coverage.

(b) **Spouse and Dependent Children**

Continuation of Coverage which commenced under either paragraph 4.b or 4.c above, will terminate for the Spouse and Dependent Children at the end of the period for which subscription charges have been paid when the first of the following events occurs:

i. A period of 36 months has elapsed, or
ii. This Agreement between the Group and HHP is canceled, or
iii. The required subscription charges for the next period are not paid, or
iv. The Member becomes covered under any other group health plan (except when the member's new group health plan restricts coverage for a pre-existing condition limitation, then continuation of coverage may continue until the pre-existing condition limitation is satisfied or until another cause for termination of continuation of coverage occurs. The continuation of coverage plan [this EOC] will be secondary in coverage to the member's new group health policy), or
v. HHP receives written notice of the Member's voluntary cancellation of coverage.

6. Other Provisions Applicable to Continuation of Coverage

(a) A Child born during the period the Subscriber is receiving Continuation of Coverage is covered for the first 31 days of life for care of illness and injury. **TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A FAMILY MEMBER WITHIN 31 DAYS, AND CONTINUATION OF COVERAGE OF THE CHILD WILL TERMINATE WHEN HIS OR HER PARENT'S CONTINUATION OF COVERAGE ENDS.**

(b) For the purposes of determining the proper subscription charges for Continuation of Coverage:

i. A Spouse whose Continuation of Coverage commences under paragraph 4.b, above will be considered a Subscriber, and
ii. A Child whose Continuation of Coverage commences under paragraph 4.c, above will be considered a Subscriber.

(c) If a Member is covered under another carrier's Continuation of Coverage when the Group changes coverage to HHP, the term of Continuation of Coverage provided that Member by HHP will be reduced by the period coverage was continued under the prior carrier's plan.

C. Extension, Under Internal Revenue Code, Due to Disability

Section 6707 provides that in case of a Member who is determined under title II (OASDI) or XVI (SSI) of the Social Security Act to have been disabled at the time of the qualifying event of termination of employment or reduction in hours of employment, the Member is entitled to 29 (as opposed to 18) months Continuation of Coverage, but only if the Member has provided notice of such determination before the end of the 18 months. Extended Continuation of Coverage can be terminated in the month that begins more than 30 days after the date of the final determination, under title II or title XVI of the Social Security Act, that the Member is no longer disabled.

1. Increased Premium

Employers are allowed to charge 150 percent of the applicable premium for the eleven additional months of coverage provided to disabled Members under this section.

2. Notification

Each Member who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of a qualifying event (termination of employment or reduction in hours of employment) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of the final determination that the Member is no longer disabled.

D. Nevada Continuation of Coverage Under Certain Group Policies

Employers who employ less than 20 employees and provide health care coverage for their employees are subject to comply with the Continuation of Coverage. To qualify under this legislation, the Member must have been covered by the employer's group health plan for at least 12 consecutive months prior to any of the qualifying events.

1. Qualifying events for Continuation of Coverage under the agreement are:

   (a) **Employee**

      i. Non-voluntary termination of employment for any reason other than gross misconduct.
      ii. Reduction in working hours resulting in loss of coverage.

   (b) **Employee's covered dependents**

      i. Employee's non-voluntary termination for any reason other than gross misconduct.
      ii. Reduction in working hours of the employee and spouse.
      iii. Death of the employee.
      iv. Divorce or legal separation of the employee and spouse.
      v. Eligibility of employee for Medicare benefits.
      vi. Loss of child's dependent status under requirements of the plan.

2. Notification

   (a) An employee, spouse or dependent child must notify the employer that he or she is eligible to continue coverage within 60 days after he or she becomes eligible.

   (b) The employer shall provide written notice to the employee, spouse or dependent child within 14 days after receipt of his/her notification regarding the election to continue coverage and the premium required to be paid.

   (c) The employee, spouse or dependent child must notify the insurer of his election to continue coverage within 60 days after receipt of the information provided by the employer in b above, and pay the required premium to the employer.

3. Commencement of Continuation of Coverage

If HHP receives from the Group timely notice of an election of Continuation of Coverage, together with timely payment of appropriate subscription charges, a Continuation of Coverage period not to exceed 18 months for the employee and 36 months for spouse and any dependent children for whom Continuation of Coverage is elected will commence upon:

   (a) Employee's non-voluntary termination from employment, or

   (b) Reduction in employee's working hours resulting in loss of coverage, or

   (c) Death of the employee, or

   (d) Notice of legal separation, final divorce decree, annulment or dissolution of marriage between of the employee and enrolled spouse, or

   (e) Employee's eligibility for Medicare benefits, or

   (f) Dependent child's loss of eligibility because of age or marriage.

4. Termination of Coverage

Continuation of Coverage which commenced under paragraph 3, above, for a Subscriber and/or any family members of that Subscriber will terminate at the end of the period for which subscription charges have been paid when the first of the following events occurs:

(a) A period of 18 months has elapsed for the subscriber or a period of 36 months has elapsed for dependents, or
(b) This agreement between Group and HHP is canceled, or
(c) The required subscription charges for the next period are not paid, or
(d) The employee, spouse or dependent child becomes covered under any other policy or group health insurance or Medicare, or
(e) The employee or spouse qualifies for Medicare; or
(f) HHP receives written notice of the Member's voluntary cancellation of coverage, or
(g) The spouse remarries and becomes eligible for coverage under his/her new spouse's policy of group health insurance.

5. Other Provisions Applicable to Continuation of Coverage

(a) Newborns are covered for the first 31 days of life.
TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A FAMILY MEMBER WITHIN 31 DAYS, AND CONTINUATION OF COVERAGE OF THE CHILD WILL TERMINATE WHEN HIS OR HER PARENT'S CONTINUATION OF COVERAGE ENDS.

(b) For the purpose of determining the proper subscription charges for Continuation of Coverage:

i. A spouse whose Continuation of Coverage commences under paragraph 3.c,d, or e above, will be considered a Subscriber, and
ii. A child whose Continuation of Coverage commences under paragraph 3.f, above will be considered a Subscriber.

E. Continuation of Coverage: Total Disability Under Nevada State Law

1. As used in the Part, "total disability" and "totally disabled" mean the continuing inability of the enrollee, because of an injury or illness, to perform substantially the duties related to his employment for which he is otherwise qualified.

2. This EOC provides continuing coverage for an enrollee and his/her dependent(s) who are otherwise covered by the EOC while the enrollee is on leave without pay as a result of total disability. This coverage is only for an injury or illness suffered by the enrollee which is not related to the total disability or for any injury or illness suffered by his/her dependent(s).

3. The coverage required pursuant to paragraph 2 will continue until:

(a) The date on which the employment of the enrollee is terminated;
(b) The date on which the enrollee obtains another policy of health insurance;
(c) The date on which this EOC of group insurance is terminated; or
(d) After a period of twelve (12) months in which benefits under such coverage are provided to the enrollee,

whichever occurs first.

PART XII. GENERAL PROVISIONS

A. Entire EOC.

This EOC, the Group Enrollment Contract, any Attachments hereto, and the individual applications and questionnaires, if any, of the Subscriber constitute the entire contract between the parties and as of the effective date of coverage, and supersede all other agreements between the parties. Any and all statements made to HHP by Group and any Subscriber or Family Dependent shall, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this EOC shall be used in defense to a claim under this EOC.

B. Cancellation.

Except as otherwise provided in this EOC, HHP shall not have the right to cancel or terminate any individual certificate issued to any Subscriber while this EOC remains in the eligible class of employees of the group, and his or her premiums are paid in accordance with the terms of this EOC.

C. Form or Content of EOC.

No agent or employee of HHP is authorized to change the form or content of this EOC. Such changes can be made only through endorsement signed by an authorized officer of HHP.

D. Identification Card.

Cards issued by HHP to Members pursuant to this EOC are for identification only. Possession of a HHP identification card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits, the holder of the card must, in fact, be an eligible Member on whose behalf all applicable premiums under this EOC have actually been paid. Any person receiving services or other benefits to which he/she is not entitled pursuant to the provisions of this EOC and any Member assisting such person shall be liable for the actual cost of such services or benefits or, if the actual costs cannot be determined, the Usual and Reasonable Charges of such services or benefits.

E. Authorization to Examine Health Records.

The Member, and the Subscriber on behalf of underage Members, consents to and authorizes all health care providers, including but not limited to, Physicians, Hospitals, Skilled Nursing Facilities, and other Participating Providers, to permit the examination and copying of any portion of the Member's hospital and medical records, when requested by HHP. Information from medical records of Members and information received from providers incident to the provider-patient relationship shall be kept confidential and except for use reasonably necessary in connection with government requirements established by law, may not be disclosed without the consent of the Member.

F. Notice of Claim.

If submission of a claim is required to receive benefits under this EOC, such claim shall be allowed only if notice of that claim is submitted to HHP within sixty (60) days from the date on which the covered expenses were first incurred. However, if it was not reasonably possible to give notice within the above time limit, and notice was furnished as soon as was reasonably possible, the submission date will be extended accordingly. However, in no event will benefits be allowed if notice of claim is made beyond one year from the date on which the expense was incurred.

G. Notice.

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

Chief Operating Officer
Hospital Health Plan, Inc.
400 South Wells Avenue
Reno, Nevada 89502

Or, if to a Member, at the last address known to HHP.

H. Interpretation of EOC.

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

I. Assignment.

This EOC is not assignable by Group or Members without the written consent of HHP. Benefits to which a Member is entitled under this EOC are not assignable to either a Participating or non-Participating Provider.

J. Member Grievances.

Any problem or claim between a Member and HHP or between a Member and a Participating Provider other than disagreements regarding the amount of payment on a claim must be dealt with through HHP's Grievance Procedure before pursuing relief in any other forum, e.g., court. Grievances may concern non-medical or medical aspects of care as well as the terms of this EOC, including its breach or termination. A copy of the Grievance Procedure is annexed as Attachment B.

K. Gender.

The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

L. Modifications.

By this EOC, Group makes HHP coverage available to Members who are eligible under Part II. However, this EOC shall be subject to amendment, modification, termination in accordance with any provision hereof or by mutual agreement between HHP and Group without the consent or concurrence of the Members. In addition, this EOC shall automatically be modified to comply with provisions of Nevada law. By electing medical and hospital coverage under HHP or accepting HHP benefits, all Members legally capable of contracting, and the legal representative of all Members incapable of contracting, agree to all terms, conditions and provision hereof.

M. Clerical Error.

Clerical errors or delays in keeping or reporting data relative to coverage will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise be validly terminated. Upon discovery of such errors or delays, an equitable adjustment of charges will be made. In no event, however, will credits be made retroactive more than two Premium Due Dates prior to the date that HHP is notified in writing in a form satisfactory to HHP of a requested addition/deletion to, or change in, a Member's HHP coverage status.

N. Policies and Procedures.

HHP may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate.

ATTACHMENT A

SCHEDULE OF BENEFITS AND EXCLUSIONS

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ATTACHMENT A

SCHEDULE OF BENEFITS AND EXCLUSIONS

Each Member shall select or have selected on his/her behalf a Primary Care Physician through whom certain covered primary medical services shall be provided and who will coordinate the other Covered Services to be received by the Member from other Participating Providers. If a Member receives services through a Physician or health care provider other than his/her Primary Care Physician and such services were not ordered by his/her Primary Care Physician and authorized by HHP, if applicable, pursuant to the UM/QA Protocols, those services will not be covered except in a true Emergency or for Urgently Needed Services. Members may change their Primary Care Physician by submitting a Change Form or by calling HHP's Member Services department in accordance with HHP procedures.

A Member shall be entitled to receive the medical care and services of Physicians and other Participating Providers including medical, surgical, diagnostic, therapeutic and preventive services, as set forth in Attachment A, which are generally and customarily provided in the Service Area, which are determined to be Medically Necessary AND ARE PERFORMED, PRESCRIBED, DIRECTED OR ORDERED BY A MEMBER'S PRIMARY CARE PHYSICIAN AND AUTHORIZED BY HHP PURSUANT TO THE UM/QA PROTOCOLS, IF APPLICABLE.

When two (2) courses of treatment are medically equivalent or substantially medically equivalent, as determined by HHP, HHP has the right, at its discretion, to substitute less costly services or benefits for those which would otherwise be covered or available under the EOC, even if the less costly services or benefits would not otherwise be covered. This means that if both inpatient care in a skilled nursing facility and nursing care in the home on a part time intermittent basis would be medically appropriate, and inpatient care would be less costly, HHP can limit coverage to inpatient care. Moreover, HHP can limit coverage to inpatient care even if it means extending the quantity of inpatient benefit beyond that provided in this EOC.

The fact that a Participating Physician or Provider may prescribe, order, recommend or approve a service or supply does not, of itself, make it a Covered Service or Medically Necessary unless such prescription, order, recommendation, or approval otherwise complies with the HHP's UM/QA Protocols, the definition of Medically Necessary in Part I(S), even though it is not specifically listed as an exclusion, and is expressly provided for herein.

Member shall not obtain a vested interest in any Covered Service merely by virtue of the fact that the Member has begun to receive a Covered Service. HHP may amend or terminate this EOC according to the Group Enrollment Contract and Member shall not have a vested interest in continued coverage under this EOC or any Covered Service, except as set forth in Part XI.

HHP WILL NOT COVER SERVICES RENDERED TO A MEMBER IF A MEMBER CONSULTS A PHYSICIAN OR HEALTH PROFESSIONAL WITHOUT A REFERRAL FROM HIS/HER PRIMARY CARE PHYSICIAN AND AUTHORIZED BY HHP PURSUANT TO THE UM/QA PROTOCOLS, IF APPLICABLE, EXCEPT IN AN EMERGENCY OR FOR URGENTLY NEEDED SERVICES.

<u>BE SURE TO REVIEW ALL THE EXCLUSIONS IN SECTION H, OF THIS ATTACHMENT A, EVEN IF A BENEFIT APPEARS TO BE OTHERWISE PROVIDED AND EVEN IF SOME EXCLUSIONS ARE SET FORTH ALONG SIDE THE BENEFIT DESCRIPTION.</u>

A MEMBER WILL BE LIABLE FOR CERTAIN COPAYMENTS TO PROVIDERS OF SERVICES FOR SPECIFIED SERVICES AS SET FORTH IN THE "SCHEDULE OF COPAYMENTS" ANNEXED AS ATTACHMENT C.

A. **Professional Services Performed Within HHP's Service Area**

1. Medical Care and Preventive Services. Medically Necessary medical care and services, including office visits and consultations, Hospital and Skilled Nursing Facility visits, periodic physical examinations including well baby care, allergy testing and serum, influenza immunizations, chemotherapy (including chemotherapy drugs), screening pap smear, podiatric care, vision and hearing screening through age 17 to determine the need for hearing and vision correction, pediatric immunizations in accord with accepted medical practice are covered when ordered by Member's Primary Care Physician. Services of specialty physicians are covered when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols. Member is entitled to not more than one routine gynecological examination per calendar year to include, a pap smear, pelvic examination, urinalysis and breast examination. In addition, the member is entitled to a mammogram according to the following schedule: an initial baseline mammogram for female members ages 35 to 39 and annual mammograms for women 40 years of age and older.

2. Surgical and Obstetrical Physician Services. Medically Necessary surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care are covered when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

3. Laboratory Procedures and X-ray Examinations. Medically Necessary x-ray and laboratory procedures, services and materials, including diagnostic x-rays, x-ray therapy, mammogram (see Section A(1), above), fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services, are provided when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

4. Home Health Care.

(a) House Calls. Medically Necessary house calls shall be provided within the Service Area by Member's Primary Care Physician or Participating Providers as the nature of the illness dictates, as ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(b) Home Care. Medically Necessary care in the home by Physician-supervised health professionals other than Physicians, provided in the Service Area by a Home Health Agency when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols. Such care will not be available if it is substantially or primarily for Member's convenience and, further, it would be rare in terms of case management for care to be provided in the home except on a part-time and intermittent basis.

Home Health Care does not include over-the-counter durable medical equipment, over-the-counter supplies or any Prescription Drugs. These benefits are only available to the extent that they are covered elsewhere in the EOC or Rider.

5. Family Planning. Medically Necessary services, counseling and planning for problems of fertility and infertility are available when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols, and include vasectomies, tubal ligations. Infertility services are limited to: general history and physical examination (progesterone level, VDRL, CBC, urinalysis, SMAC-12, T3, T4, TSH and T6), pap smear, endometrial biopsy, HSG, Sims-Huhner, three (3) separate semen analyses, semen culture, FSH and LH, and related services by Participating Providers to repair the natural functioning of the body. Fertility services are limited to a life-time maximum of $5,000.

Unless explicitly noted above, no other fertility or infertility services are covered. Prescription (infertility) Drugs are not covered unless otherwise provided in a Pharmacy Rider.

6. Ambulance Services. Medically Necessary ambulance service is provided in an Emergency without the prior approval of Member's Primary Care Physician. Medically Necessary ambulance services are provided in a non-Emergency setting when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols. In all cases coverage is limited to the Usual and Reasonable Charge.

7. Oral Surgery. Although general dental services are not provided, the following limited Medically Necessary oral surgical procedures will be provided in an inpatient or outpatient setting when prescribed by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols, in connection with: the accidental injury to the jaw bones or surrounding tissues when the injury occurs and the repair takes place while an Eligible Member of the Plan and then, services must commence within fifteen (15) days after the accidental injury (services that commence after 15 days are not covered); the correction of non-dental physiological conditions which have resulted in a severe functional impairment; and treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.

8. Maternity Care and Care of Newborns. Medically Necessary Hospital and medical services for pregnant Members, including prenatal and postpartum care and related delivery room and ancillary services are covered when ordered by Member's Primary Care Physician or attending obstetrician and authorized by HHP pursuant to the UM/QA Protocols. The coverage, benefits and services for newborn children shall consist of coverage for normal newborn care as well as injury or sickness, including the Medically Necessary care or treatment of congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest appropriate facility staffed and equipped to treat the newborn's condition, when such transportation is ordered by Member's Primary Care Physician or attending obstetrician and authorized by HHP pursuant to the UM/QA protocols.

9. Short-Term Rehabilitative Therapy. For each acute condition or complex of acute interrelated conditions (multiple problems and/or sites in the same body region) which are related to the same acute causal event but not including conditions for which rehabilitative services have previously been provided, Medically Necessary short-term speech, physical, and occupational rehabilitative therapy for Acute conditions on a basis, as limited below, will be provided when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(a) Outpatient Short Term Rehabilitative Services are limited to treatment of conditions which are subject to significant clinical improvement over a 3 month (90 day) period from the date inpatient or outpatient therapy commences which outpatient services are not to exceed twenty (20) visits each for speech, physical and occupational therapy.

(b) Inpatient Care Short Term Rehabilitative Services are limited to treatment of conditions which are subject to significant clinical improvement over a continuous thirty (30) day period from the date inpatient therapy commences in a distinct rehabilitation unit of a Hospital, Skilled Nursing Facility or other facility approved by HHP.

This benefit does not apply to rehabilitative services for drug and alcohol abuse. Rehabilitative services for drug and alcohol abuse are covered in Section A(16) of this Attachment A.

10. Hospice Services. Hospice Care is an alternative approach to caring for the terminally ill. HHP's case managers will coordinate services with family and a home health agency to provide benefits that assist Members and their families with their care.

To qualify for Hospice Care services, the patient must have a life expectancy of six (6) months or less as certified by his/her Primary Care Physician, have a responsible care giver at home, and authorized by HHP pursuant to the UM/QA Protocols. The Hospice Care benefit has a 180 day maximum benefit period beginning on the first day of Hospice Care services and ending 180 days later or on the death of the terminally ill patient.

Hospice Care is limited to home care services commonly provided in hospice programs, as well as family services, which consist of:

- a maximum of 12 bereavement visits by or to a social worker or counselor associated with the hospice program are available to family members beginning on the death of the terminally ill Member and ending one year after the Member's death; and
- respite care, limited to three periods of 48 hours in the 180 day benefit period; and
- counseling services to family members provided by the hospice program, limited to a maximum of twelve (12) counseling sessions within the 180 day benefit period. Home care in the Hospice Care program is provided in addition to the Home Health Services covered under this EOC.

11. Kidney Dialysis Services. Medically Necessary kidney dialysis services and related therapeutic services and supplies, e.g., epogen, for the treatment of end stage renal disease to the extent not covered by the Medicare Program not to exceed $30,000 in any twelve (12) consecutive months, when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

12. Podiatry Services. Medically necessary podiatry services limited to the treatment of acute conditions of the foot, such as infections, inflammation, or injury and other foot care which is disease related, will be performed by a podiatrist only by referral from and under the direction of the Member's Primary Care Physician. Routine foot care services, such as removal of callus, paring of corns, nail care, any and all orthotics and orthoses, etc., are excluded from coverage.

13. Orthopedic and Prosthetic Devices.

(a) Medically Necessary orthopedic devices are limited to:

i. braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays;
ii. splints;
iii. devices for congenital disorders; and
iv. post- and peri-operative devices;

when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols. All other orthopedic devices are specifically excluded.

(b) Medically Necessary prosthetic devices, i.e., devices required to substitute for missing or non-functioning body parts or organs, except as specifically excluded in this Attachment, are limited to the initial non-experimental and non-investigational device and/ or appliance provided in connection with an illness or injury to the Member subsequent to Member's effective date of coverage under this EOC as well as adjustment of initial Prosthetic Device when ordered by Member's attending Participating Physician and authorized by HHP pursuant to the UM/QA Protocols. Replacement prosthetic devices are not covered.

This benefit does not apply to prosthetic devices following a mastectomy. Prosthetic devices following a mastectomy are covered in Section A(17) of this Attachment A.

14. Durable Medical Equipment or DME. DME is equipment which can withstand repeated use; is primarily and usually used to serve a medical purpose and not substantially for a Member's personal comfort or convenience; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, durable medical equipment must be Medically Necessary and prescribed by Member's Primary Care Physician for use in Member's home and be authorized by HHP pursuant to its UM\QA Protocols.

DME includes oxygen equipment, wheelchairs, hospital beds, warning or monitoring devices for infants suffering from recurrent apnea (3-month benefit), and other items that HHP determines are Medically Necessary. Replacement or repair, is not a benefit. Durable medical equipment is the property of HHP and shall be returned to HHP after it is no longer Medically Necessary for the Member or coverage ceases. In addition, the following specific durable medical equipment will not be covered: (a) hearing aids, (b) cochlear implants, and (c) deluxe equipment, i.e., any equipment having features which do not serve a specific therapeutic purpose or which is not necessitated by the Members's medical condition.

15. Mental Health Services. Coverage for Medically Necessary Mental Health Services when ordered by Member's attending Participating Physician and authorized by HHP pursuant to the UM/QA Protocols is limited to evaluation, crisis intervention and Short-Term psychotherapy which therapy in the judgement of Member's Primary Care Physician and mental health professional, and consistent with the UM/QA Protocols, will lead to significant clinical improvement within a 60 day continuous period.

(a) Outpatient Mental Health Services are available up to a total of 25 individual visits of 50 minutes duration or 25 group visits of 50 minutes duration, or any combination, not to exceed a total of 25 visits in each calendar year.

(b) Inpatient Mental Health Services in a Hospital, psychiatric Hospital or residential treatment facility up to twenty-one (21) days per calendar year or forty-two (42) days per lifetime under HHP coverage.

16. Alcohol and Substance Abuse Services. Medically Necessary outpatient and inpatient care for alcohol and drug abuse when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols, subject to the limits set forth below. Substance Abuse Services are limited to diagnosis, medical treatment and medical aspects of rehabilitation. Referral for non-medical ancillary services will be made, but services provided the Member after such referral will not be covered. The combined maximum for all three types of treatment covered under this Section 16 is $39,000 during a Member's lifetime.

(a) **Medically Necessary Covered Services for:**

i. treatment for withdrawal from the physiological effects of alcohol or drugs up to $1,500 each calendar year, and subject to limits and/or conditions of subsection (b) of this Section 16.

ii. rehabilitative treatment for a Member up to $9,000 each calendar year, and subject to the limits and/or conditions of subsection (b) of this Section 16.

iii. outpatient counseling, including group and family counseling up to $2,500 each calendar year, for a Member who is not admitted as an inpatient under subsection (a)ii of this Section 16, and subject to the limits and/or conditions of subsection (b) of this Section 16.

(b) Benefits for Covered Services listed in subsection (a) of this Section 16 will be paid in the same manner as benefits for those services for any other illness covered by the EOC provided that treatment is received in or provided by a:

i. private or public institution which provides physical or mental restoration for alcohol or drug abusers and is certified by the Bureau of Alcohol and Drug Abuse, Rehabilitation Division of the Department of Human Services of Nevada and otherwise duly licensed by the State of Nevada, but not including services offered by volunteers or voluntary organizations.

ii. hospitals or other institutional providers if duly licensed by the Health Division, Department of Human Resources of Nevada, accredited by JCAHO and providing a program for the treatment of alcoholism or drug abuse as part of its accredited activities.

17. Mastectomy Reconstructive Surgery. If a covered mastectomy is performed on a Member, coverage will include the expense for breast reconstructive surgery and for up to two (2) prosthetic devices subject to all the terms and conditions of this EOC. If reconstructive surgery is begun within three (3) years after the mastectomy, coverage will be extended to the member or ex-member for all eligible charges for such reconstructive surgery as would have been provided at the time of the mastectomy. If the surgery is begun more than three (3) years after the mastectomy, the benefits provided are subject to all the terms, conditions and exclusions contained in the EOC in effect at the time of the reconstructive surgery.

18. Organ Transplants. When ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols, the following organ transplants are Covered Services when the Member is the organ recipient: kidney transplants, and liver transplants for children with biliary atresia and such other transplants as are required to be covered by federally qualified health maintenance organizations. The following related services shall also be provided: tests necessary to identify an organ donor, the reasonable expense of acquiring the donor organ, transportation of the donor organ, but not the donor, and the expense of life support where such support is for the sole purpose of removing the donor organ.

Covered Services for organ transplants do not include:

(a) services of a Member where the Member serves as the donor of the donor organ except as provided above;
(b) transplants utilizing any animal organs;
(c) any transportation of the donor as opposed to transportation of the donor organ only;
(d) any expenses associated with an organ transplant where an alternative remedy is available;
(f) any human organ transplant not listed above or transplants which consist of the installation of a nonhuman device or artificial organ such as, but not limited to, heart, lung, heart-lung, kidney, pancreas, bone marrow, cornea, and liver; and
(g) outpatient immunosuppressive drugs when used as supportive therapy for organ transplants after the first year following transplant services received while a enrolled in HHP.

B. Hospital Services in Hospitals and Skilled Nursing Facilities

Hospital Services will be covered only when provided to the Member by a Participating Provider, except in the event of an Emergency or for Urgently Needed Services, when determined to be Medically Necessary, ordered by Member's Primary Care Physician, and authorized by HHP pursuant to the UM/QA Protocols.

1. Inpatient Services. Hospital Services include, but are not limited to, semi-private room and board (private room when Medically Necessary), unlimited days, general nursing care and the following additional facilities, services, and supplies on an inpatient basis, when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols, to the extent applicable: meals and special diets when Medically Necessary, use of operating room and related facilities, use of intensive care or cardiac care units and related services,
x-ray services, laboratory and other diagnostic tests, non-experimental and non-investigational Prescription Drugs, biologicals, anesthesia and oxygen services, blood and blood plasma and its administration, special duty nursing when Medically Necessary, radiation therapy, inhalation therapy, and chemotherapy (including chemotherapy drugs).

2. Outpatient Services. When prescribed by Member's Primary Care Physician and authorized pursuant to the UM/QA Protocols, Medically Necessary hospital services such as radiotherapy, chemotherapy (including chemotherapy drugs) and outpatient surgery.

3. Skilled Nursing Facility. Medically Necessary services provided in a Skilled Nursing Facility for non-custodial care will be covered when Medically Necessary and prescribed by Member's Primary Care Physician and authorized pursuant to UM/QA Protocols. Prior care in a Hospital is not required before being eligible for care in a Skilled Nursing Facility. Custodial or domiciliary care in a Skilled Nursing Facility or elsewhere is not covered.

C. **Emergency Services Within the Service Area**

1. Medical Care and Notification. Medically Necessary medical care is available through Participating Physicians seven (7) days a week, twenty-four (24) hours a day. If injury or illness requires Emergency Services, the Member must notify and obtain authorization from his/her Primary Care Physician (PCP) before receiving Emergency medical services or, if that is not possible, as soon as possible but no more than twenty four (24) hours after the onset of the Emergency except as provided in Subsection 2 of this Section C. All Emergency Services will be covered if Medically Necessary.

2. Extended Notification. If the Member or a family member is unable to contact his/her PCP before receipt of Emergency medical services or within twenty-four (24) hours of the Emergency due to shock, unconsciousness, or otherwise, the Member must, at the earliest time reasonably possible, contact HHP to receive authorization for care.

3. Payment. Payment for services of non-Participating providers before the Member can, without medically harmful or injurious consequences, utilize the services of a Participating Provider, shall be limited to expenses for such care required up to the Usual and Reasonable Charges for such services.

4. Ambulance Services. Direct reimbursement for medically necessary ambulance service is provided in an Emergency without the prior approval of Member's Primary Care Physician up to the Usual and Reasonable Charge and subject to the provisions of Section A(6) of this Attachment A.

5. Follow-Up Care. Continuing or follow-up treatment for an Emergency is limited to care required before the Member can, without medically harmful or injurious consequences, transfer to a Participating Provider. Benefits for continuing or follow-up treatment are otherwise provided only from Participating Providers, subject to all provisions of this EOC.

D. **Emergency Services Provided Outside the Service Area**

1. Medical Care and Notification. Medically Necessary Out-of-Area Emergency Services will be covered based on Usual and Reasonable Charges for all Medically Necessary Covered Services. Out-of-Area Emergency Services are provided only if HHP is notified before the receipt of those services or as soon as possible after such Emergency Services, but no more than twenty-four (24) hours after onset of the Emergency, except as provided in subsection 2 of this Section D.

2. Extended Notification. If the Member or a family member is unable to contact HHP before receipt of those services or within twenty-four (24) hours of the Emergency due to shock, unconsciousness, or otherwise, the Member must, at the earliest time reasonably possible, contact HHP to receive authorization for care.

3. Payment. Payment for services rendered by non-Participating Providers for Emergency Services provided outside the Service Area shall be limited to expenses for such care required before the Subscriber can, without medically harmful or injurious consequences, utilize the services of a Participating Provider, up to the Usual and Reasonable Charges for such services as defined herein.

4.. Ambulance Services. Direct reimbursement for medically necessary ambulance service is provided in an Emergency situation without the prior approval of the Primary Care Physician up to the Usual and Reasonable Charge and subject to the provisions of Section A,6 of this Attachment.

5. Follow-Up Care. Continuing or follow-up treatment for an Emergency Service is limited to care required before the Member can, without medically harmful or injurious consequences, return to the Service Area and receive care from Participating Providers, as determined by HHP. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area from Participating Providers, subject to all provisions of this EOC.

6. Limitations. Out-of-Area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area are not covered. For example, childbirth outside the Service Area if the Member had entered her third trimester of pregnancy is not covered. However, unanticipated complications of pregnancy or premature delivery are covered outside the Service Area.

E. Urgent Care Services Within the Service Area

1. Medical Care and Notification. Medically Necessary medical care is available through Participating Physicians seven (7) days a week, twenty-four hours a day. If injury or illness requires **Urgent Care Services**, the Member must notify his/her Primary Care Physician or HHP before receiving medical services. All Urgent Care Services will be covered if Medically Necessary.

2. Provider/Time Specific. All Urgent Care services must be obtained through a contracted Urgent Care provider. Urgent Care services obtained from a non-contracted, in-service area, provider is not a covered benefit. In addition, urgent care services may be available at certain Urgent Care providers (as shown HHP's provider directory) only during predetermined hours.

3. Follow-Up Care. Continuing or follow-up care for an Urgent Care service is limited to care required before the Member can, without medically harmful or injurious consequences, transfer to the Member's Primary Care Physician. Benefits for continuing or follow-up treatment are otherwise provided only from Primary Care Physician, subject to all provisions of this EOC.

4. Limitations. Urgent Care Services obtained at a contracted hospital emergency facility are limited to a maximum total benefit of $250.00 (including the member's copayment).

F. Urgent Care Services Provided Outside the Service Area

1. Medical Care and Notification. Medically Necessary Out-of-Area Urgent Care Services are covered based on Usual and Reasonable Charges for all Medically Necessary Covered Services. Out-of-Area Urgent Care Services are provided only if HHP is notified before the receipt of those services or as soon as possible after such Urgent Care Services, but no more than forty-eight (48) hours after the onset of the Urgent Care Service, except as provided in subsection 2 of this section.

2. Extended Notification. If a Member or family member is unable to contact HHP before receipt of those services or within forty-eight (48) hours of the Urgent Care due to shock, unconsciousness, or otherwise, the Member must, at the earliest time reasonably possible, contact HHP to receive authorization for care.

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3. Payment. Payment for services rendered by non-Participating Providers for Urgent Care Services provided outside the Service Area shall be limited to expenses for such are required before the Subscriber can, without medically harmful or injurious consequences, utilize the services of a Participating Provider, up to the Usual and Reasonable Charges for such services as defined herein.

4. Follow-Up Care. Continuing or follow-up treatment for Urgent Care Services is limited to care required before a Member can, without medically harmful or injurious consequences, return to the Service Area and receive care from Participating Providers, as determined by HHP. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area from Participating Providers, subject to all provisions of this EOC.

5. Limitations. Out-of-Area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area are not covered. For example, childbirth outside the Service Area if the Member had entered her third trimester of pregnancy is not covered. However, unanticipated complications of pregnancy or premature delivery are covered outside the Service Area.

Urgent Care Services obtained in a hospital emergency facility are limited to a maximum total benefit of $250.00 (including the Member's copayment).

G. **Temporomandibular Joint Syndrome or Dysfunction (TMJ)**

Temporomandibular Joint Syndrome or Dysfunction (TMJ) services are covered only where the required services are not recognized dental procedures. Where the service is not a recognized dental procedure, benefits will be provided if medically necessary, ordered by the member's Primary Care Physician, and authorized by HHP prior to the date of service and pursuant to HHP's UM/QA protocols. Benefits are further limited to the lesser of 50% of the billed charges; or $2,500.

H. **Limitations and Exclusions.**

1. Limitations. In the event the provision of Covered Services provided under this EOC are delayed or rendered impractical due to circumstances not within the control of the HHP, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of significant part of Participating Provider's personnel or similar causes, HHP shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the HHP and Participating Providers shall render the Covered Services provided under this EOC insofar as practical, and according to their best judgment; but HHP and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

2. Exclusions. Except as specifically provided in a Rider, if any, the following services and benefits are excluded from coverage.

(a) Services of non-Participating Providers, except in an Emergency, for Out-of-Area Urgently Needed Services, or when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(b) Services which are not medically necessary or not required in accordance with accepted standards of medical practice in the Service Area.

(c) Cosmetic surgery or medical procedures, defined as any plastic or reconstructive surgery or medical procedures done primarily to improve the appearance of any portion of the body, and from which no substantial clinical improvement in physiologic function could be reasonably expected. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation or reduction procedures, rhinoplasty and associated surgery, epikeratophakia surgery, any augmentation or reduction procedures or correction of facial or breast asymmetry (except breast asymmetry will be provided pursuant to Section A 17 of this Attachment A), treatment of male-pattern baldness or hair treatment, keloid scar therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions, unless medically necessary, and complications (except infection or disease resulting from excluded cosmetic surgery or medical procedures). For the purpose of this EOC, psychological factors (for example, for self-image, difficult social or peer relations) are not relevant and do not constitute a physical bodily function or Medical Necessity.

(d) Surgical or invasive treatment (including gastric balloon), or reversal thereof, gastric stapling, for reduction of weight regardless of associated medical or psychological conditions, including treatment of complications resulting from surgical treatment of obesity, unless determined by HHP to be Medically Necessary by HHP in advance of treatment.

(e) Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations as well as penile implants and services and supplies related to implants.

(f) Services to reverse voluntary surgically-induced infertility, sex-change procedures, maternity services related to a Member serving in the capacity of a surrogate mother, in vitro fertilization, Prescription (infertility) Drugs, and any infertility or infertility services, except as otherwise specifically set forth elsewhere in the EOC.

(g) Routine physical examinations primarily for insurance, licensing, school, sports, employment, as well as other third-party physicals.

(h) Dental care, including but not limited to treatment on or to the teeth, extraction of teeth, repair of injured teeth, general dental services, treatment of dental abscesses or granulomas, treatment of gingival tissues (other than for tumors), dental examinations, mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service customarily provided by a dentist, except as otherwise specifically set forth elsewhere in the EOC. In addition, treatment to the gums and treatment of pain or infection known or thought to be due to dental cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthoses or protheses are not covered benefits.

(i) Services for the treatment of temporomandibular joint syndrome or dysfunction are not covered where the services are recognized dental procedures. For purposes of this EOC, "recognized dental procedures" include, but are not limited to, the extraction of teeth, the application of orthodontic devices and splints, and services rendered by a licensed dentist or doctor of oral surgery as opposed to a Physician. Where the service is not a recognized dental procedure, benefits will be provided if Medically Necessary, ordered by the Member's Primary Care Physician, and authorized by HHP pursuant to the UM/QA Protocols. Benefits for the treatment of temporomandibular joint syndrome are further limited to the lesser of (a) fifty percent of the billed charges, or (b) $2,500.00.

(j) Custodial, domiciliary care or homemaker services as well as the cost of care rendered by an individual related to, or a part of, Member's family.

(k) Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or nursing home, or any similar institution, regardless of how denominated.

(l) Non-medical services, acupuncture, pain therapy and treatment for the removal of varicose veins, except as otherwise specifically set forth in EOC.

(m) Long-term physical therapy and long-term rehabilitative services.

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(n) Immunizations for travel.

(o) Personal, beautification, or comfort items for inpatients in a Hospital or Skilled Nursing Facility.

(p) Private duty nursing and private rooms in an inpatient setting, unless Medically Necessary, ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(q) Durable medical equipment as well as related supplies and consumables including, but not limited to, oxygen, dressings, ostomy supplies, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, heating pads, personal care or beautification items, warning and monitoring devices (except for infants suffering from recurrent apnea) and any other primarily non-medical equipment, except as otherwise specifically set forth elsewhere in the EOC.

(r) Prosthetic and orthopedic devices, except as otherwise specifically set forth elsewhere in the EOC.

(s) Hearing aids.

(t) Birth control drugs and devices including, but not limited to, IUDs, except as set forth in a Pharmacy Rider to Attachment C.

(u) Psychological services, services or treatment of mental retardation, Downs syndrome, autistic children or other mental health services, except as otherwise specifically set forth elsewhere in the EOC, as well as psychological and psychometric diagnostic testing, evaluation services, and treatment for developmental delay, learning disability, hyperactivity and attention deficit disorder (except initial diagnosis received at the member's PCP only for identification for medication purposes), or any testing or treatment which is the obligation of the school district to provide as mandated by state or federal law.

(v) Care or treatment of chronic marital or family problems; social, occupational, religious, or other social mal-adjustments; chronic behavior disorders; or chronic situational reactions.

(w) Prescription Drugs, including insulin and growth hormone, except as otherwise specifically set forth in Sections A 1 and B of this Attachment A or in a Pharmacy Rider to Attachment C.. Over-the-counter drugs and medicines, including insulin, and other substances not requiring a prescription even if ordered by a Participating Physician via a prescription, drugs consumed in a Physician's office, if other than immunizations, allergy serum, and chemotherapy drugs, except as otherwise provided in a Pharmacy Rider to Attachment C.

(x) Physician services, supplies and equipment relating to the administration or monitoring of Prescription Drugs unless the Prescription Drug is a covered benefit under Sections A 1 or B of this Attachment A or a Pharmacy Rider to Attachment C.

(y) Experimental and investigational drugs, including drugs labeled "Caution - Limited by Federal law to investigational use", as well as drugs either not approved by the Federal Drug Administration as "safe and effective" or, if so approved, which are intended to treat a medical condition for which the U.S. Food and Drug Administration (FDA) has not specifically approved its use, whether used on an inpatient or outpatient basis.

(z) Ecological or environmental medicine including, but not limited to, use of chelation or chelation therapy; orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for such treatment; electro-diagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; acupuncture; replacement of metal dental fillings; laetrile; and gerovital.

(aa) Cosmetics, dietary supplements, vitamins, diet pills, health or beauty aids, Vitamin B-12 injections (except for pernicious anemia), antihemophilic factors, including TPA, acne preparations, laxatives, except as otherwise provided above or elsewhere in this EOC.

(bb) Special formulas, food supplements or special diets including, but not limited to, Total Parental Nutrition (TPN) (except for Acute episodes where Medically Necessary, prescribed by Member's Primary Care Physician and authorized by HHP pursuant to its UM\QA Protocols.)

(cc) All experimental and/or investigational medical, surgical, or other health care procedures as set forth in Part I(G) of the EOC and all transplants, except as otherwise provided above or elsewhere in this EOC.

(dd) Services and costs associated with organ donors where the Member acts as the donor.

(ee) Ambulance service, unless Medically Necessary.

(ff) Care for military service-connected disabilities and conditions for which the Member is legally entitled to receive and for which facilities are reasonably accessible to the Member.

(gg) Care for conditions that federal, state or local law requires be treated in a public facility and care provided under federally or state funded health care programs, except the Medicaid Program, care required by a public entity, as well as care for which there would not normally be a charge.

(hh) Treatment for alcohol or drug abuse, including detoxification services, except as provided in Section A(16) of this Attachment A.

(ii) Sleep therapy (except for central or obstructive apnea when Medically Necessary, ordered by Member's Primary Care Physician, and authorized by HHP pursuant to its UM\QA Protocols), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electrohypnosis, electrosleep therapy or electronarcosis.

(jj) Non-newborn circumcisions, unless Medically Necessary.

(kk) Amniocentesis except when done in the last trimester for the purpose of determining fetal lung maturity, in the first 16 weeks for genetic testing, the need for fetal therapy, or to determine a Medically Necessary intervention for the mother when ordered by Member's Primary Care Physician and authorized by HHP pursuant to the UM/QA Protocols.

(ll) Non-symptomatic foot care such as the removal of warts (except planters warts), corns or callouses and including, but not limited to, podiatric treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain.

(mm) Court-ordered treatment or hospitalization, unless otherwise covered by the EOC and determined to be medically necessary by HHP.

(nn) Kidney dialysis or artificial kidney treatments when covered by the Medicare Program or other federal or state programs, other than the Medicaid Program.

(oo) Services for the treatment of suicide, attempted suicide, or intentionally self-inflicted injury, whether the Member is sane or insane, including use of illegal and/or controlled substances, e.g., cocaine, valium.

(pp) Any injury sustained in the commission of a criminal offense.

(qq) Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation and employment counseling.

(rr) Ophthalmological services provided in connection with the testing of visual acuity for the fitting for eye glasses or contact lenses, except as set forth in Section A 1 of this Attachment A. The furnishing or replacing of eye glasses or contact lenses shall not be a benefit, except coverage for the first pair of eye glasses and/or contact lenses following cataract surgery. Radial keratotomy is not covered.

(ss) Charges for care or services provided before the effective date or after the termination of coverage under this EOC.

(tt) Any services or supplies not specifically listed in this EOC as covered benefits, services, or supplies.

ATTACHMENT B

MEMBER GRIEVANCE PROCEDURE

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MEMBER GRIEVANCE PROCEDURE

Complaints about medical services are best handled at the medical service site level before being brought to HHP. If a Member contacts HHP 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.

The following procedures will be followed if medical service site matter cannot be resolved at the site or if it involves a Contract Issue.

Members shall be bound to exhaust these grievance procedures unless otherwise explicitly waived, in writing, by HHP prior to instituting any claim, at law or in equity, in any court or other forum.

A. Definitions

1. Informal Complaint: A complaint which is directed to the HHP Member Services Department via phone or walk in. If an Informal Complaint is resolved, the matter ends.

2. Formal Complaint: A complaint filed in writing which the Member Services Department investigates. If a Formal Complaint is resolved, the matter ends.

3. Formal Grievance: If a Formal Complaint is not resolved to the Member's satisfaction, a Member may then file a Formal Grievance. A Formal Grievance is submitted in writing and reviewed by the Grievance Committee.

4. Grievance Committee: A committee of three or more persons, chaired by the Vice President of Operations, or his/her designee, and comprised of such other persons as the Chairperson deems appropriate.

B. Procedures

HHP has established criteria for dealing with two types of issues:

- Contract Issues: Questions relating to eligibility, commencement or termination of coverage, re-enrollment, etc.
- Health Services Issues: Questions relating to waiting times, referrals, telephone access, etc.

1. Informal Complaint

A Member who questions the manner in which health services are arranged or delivered is entitled to request that the Member Services Department investigate and resolve the matter. All Informal Complaints must be made to the Member Services Department within sixty (60) days of the event(s) giving rise to the complaint. Extensions may be given where there is reasonable cause. Informal Complaints not filed in a timely manner will be deemed waived for purposes of the HHP's Grievance Procedures as well as for all actions at law or equity.

Upon the initiation of an Informal Complaint, the Member Services representative will record at least the following information:

- name of person on whose behalf the complaint is filed (Complainant);
- Complainant's name and HHP identification number;
- name of person(s) involved;
- date(s) of occurrence;
- location;
- nature of complaint; and
- name of person filing the complaint.

If the problems concern a Health Service Issue, Member Services will contact the appropriate Provider to ascertain additional details and attempt to resolve the matter. The Provider will be requested to respond to the complaint within five (5) working days.

If the complaint involves a Contract Issue, Member Services will contact the appropriate HHP administrative staff personnel.

In either case, the Member Services representative will inform the Member of the resolution or proposed resolution of the complaint within thirty (30) days, unless additional time is required for fact-finding and investigation.

If the proposed resolution to the Informal Complaint is not acceptable to the Member, the Member is entitled to file a Formal Complaint.

2. Formal Complaint

When an Informal Complaint is not resolved in a manner which is satisfactory to the Member, the Member may file a Formal Complaint. Exhaustion of the Informal Complaint is a precondition to filing a Formal Complaint unless explicitly waived, in writing, by HHP. The Formal Complaint must be submitted in writing to the Director of Member Services within thirty (30) days after the Member has been informed of the resolution of the Informal Complaint. Extensions may be given if there is reasonable cause. Formal Complaints not filed in a timely manner will be deemed waived for purposes of the HHP's Grievance Procedures.

The Formal Complaint shall contain, at a minimum:

- Complainant's name (or name of Complainant and Complainant's representative in cases of a minor, or incapacitated or aged Member), address, and telephone number;
- Complainant's HHP identification number, Group number, and Group name; and
- A brief statement of the nature of the matter.

A Member Services representative will investigate the information and the proposed resolution to the Informal Complaint. The representative will contact the appropriate Provider or staff member concerning the Complaint. When the investigation is complete, the information will be reviewed by the Director of Member Services who will determine the appropriate resolution to the Formal Complaint. The Member Services representative will inform the Member in writing of the resolution within thirty (30) days of receipt of the Formal Complaint.

If the proposed resolution to the Formal Complaint is not acceptable to the Member, the Member is entitled to file a Formal Grievance. The Member will be informed of this right and will be sent a copy of this Grievance Procedure by the Member Services representative.

3. Formal Grievance

When a Formal Complaint is not resolved in a manner which is satisfactory to the Member, the Member may initiate a Formal Grievance. This Grievance must be submitted in writing within ten (10) working days after the Member has been informed of the resolution or the proposed resolution to the Formal Complaint. Extensions may be given if there is reasonable cause. Exhaustion of the Informal and Formal Complaint procedures is a precondition to filing a Formal Grievance although this requirement may be waived by the Grievance Committee in the exercise of its sole discretion. Formal Grievances not filed in a timely manner will be deemed waived for purposes of the HHP's Grievance Procedures.

The written request shall be on a Request for Formal Hearing Form made available by HHP upon request by Member and submitted to the Chief of Operations. At a minimum, this form shall elicit the following information:

- Complainant's name (or name of Complainant and Complainant's representative in cases of minor, or incapacitated or aged Member), address, and telephone number;
- Complainant's HHP identification number, Group number, and Group name; and
- A brief statement of the nature of the matter including the relief requested and whether a formal presentation to the Grievance Committee is desired.

The Grievance Committee shall determine if a formal presentation is appropriate and, if so, shall make every reasonable effort to schedule one at a time mutually convenient to the parties. Repeated refusal on the part of the Complainant to cooperate in the scheduling of the formal presentation shall relieve the Grievance Committee of the responsibility of hearing a formal presentation, but not of reviewing the Grievance. If a formal presentation is granted, the Complainant will be permitted to have assistance in presenting the matter to the Committee,including representation by Complainant's counsel. However, HHP must be notified at least one week prior to the date of the scheduled formal presentation of the Complainant's intention to be represented by counsel and/or to have others present during the formal presentation.

Upon receipt of the Request for Formal Hearing, the request will be forwarded to the Chairperson of the Grievance Committee along with all available documentation relating to the Grievance.

The Grievance Committee shall consider the Grievance, conduct a formal presentation if applicable, obtain additional information from the Complainant and/or staff as it deems appropriate, and make a decision and communicate its decision to Complainant within thirty (30) days after receipt of the Request for Formal Hearing. Extensions may be required if additional information or formal presentation is conducted.

4. Appeal to the HHP's Chief Executive Officer ("CEO")

If, after the Grievance Committee's decision has been rendered, the Complainant is still dissatisfied, he or she may ask for a review by the CEO of the HHP, which is the final level of appeal. The CEO shall conduct his/her review based upon the written record, the Complainant's written appeal to the CEO, the decision made by the Grievance Committee, and such additional information as the CEO may choose to elicit. The CEO may affirm, reverse or modify, in whole or in part, the decision of the Grievance Committee.

This request for review by the CEO must be in writing and be presented to the Member Services Department within ten (10) working days after receipt by the Complainant of the Grievance Committee decision. The decision of the CEO of HHP to affirm, reverse or modify, in whole or in part, the original decision of the Grievance Committee will be sent to the Complainant within five (5) working days by registered United States Mail.

5. Independent Medical Evaluation

In the event HHP requires an Insured to undergo an independent evaluation for any final determination of medical or chiropractic benefits or care, 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 evaluation. The independent evaluation will include a physical examination of the Member, unless he.she is deceased, and a personal review of all x-rays and reports prepared 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 10 working days after the evaluation. If the Member disagrees with the findings of the evaluation, he must submit an appeal to the HHP for binding arbitration within 30 days after he receives the finding of the independent medical evaluation. Upon receipt of the Member's notice of appeal, HHP will not limit or deny coverage for care related to a disputed claim while the dispute is in arbitration, except that, if HHP prevails in the arbitration, the primary treating Physician or Chiropractor may not recover any payment from either HHP or the Member for services he/she provided to the Member after receiving written notice concerning the appeal of the Member.

6. Arbitration

In the event the Member is dissatisfied with the findings of an independent evaluation or with the findings and rulings of the CEO, or if HHP is dissatisfied with the findings of an independent evaluation or the decision of the Grievance Committee or the CEO, either the Member or HHP shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules then in effect adopted and applied by the American Arbitration Association. The arbiter shall be selected by mutual agreement of HHP and the Member. The costs and expense of arbitration shall be paid by the party initiating the demand of arbitration. The decision of the arbiter shall be binding upon the Member and HHP, and arbiter's ruling shall be enforceable pursuant to state law.

Members shall be bound to exhaust these grievance procedures unless otherwise explicitly waived, in writing, by HHP prior to instituting any claim, at law or in equity, in any court or other forum.