

Group:	Desert Ridge Development Corp	Plan Year:	January 1, 2026 – December 31, 2026
Group ID:	MCA-4471	Plan Year Type:	Calendar Year (January 1 – December 31)
Plan Name:	Vista Access PPO	Enrolled Members:	15
Issuer:	Mojave Crest Assurance Company (MCA)	State of Issue:	Nevada

Vista Access PPO — Plan Year 2026

Certificate of Coverage issued to: Desert Ridge Development Corp | Group ID: MCA-4471

This document is an excerpt of the Certificate of Coverage providing detailed descriptions of medical and behavioral health benefits. Pharmacy, dental, and vision benefits are provided under separate riders. This Certificate is subject to the terms of the Group Policy Agreement between Mojave Crest Assurance Company and the Group Administrator.

IMPORTANT NOTICES

Nevada Regulated Health Insurance. This Certificate of Coverage is issued pursuant to a Group Health Insurance Policy delivered in the State of Nevada. MCA is licensed as a health insurer under Nevada Revised Statutes Chapter 689B and is subject to the managed care provisions of NRS Chapter 695G. Benefit determinations are governed by Nevada law.

Scope of This Document. This Certificate describes medical and behavioral health benefits provided under the Vista Access PPO plan. Pharmacy, dental, and vision benefits, if elected, are provided under separate riders or certificates and are not described herein.

Policy Version. Medical necessity determinations for covered services are made pursuant to MCA clinical policies in effect on the date of service, not the date of review. The applicable policy version is determined by the date of service.

Mental Health Parity. MCA complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and NRS 695G.170. Financial requirements and treatment limitations applicable to mental health and substance use disorder (MH/SUD) benefits are no more restrictive than those applicable to medical and surgical benefits in the same classification.

SCHEDULE OF BENEFITS

This schedule summarizes your cost-sharing obligations. All cost sharing applies after the applicable deductible unless noted otherwise. Amounts shown are per Member per Plan Year unless stated otherwise.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible — Individual	\$520	\$1,560
Annual Deductible — Family	\$1,040	\$3,120
Out-of-Pocket Maximum — Individual	\$4,200	\$8,400
Out-of-Pocket Maximum — Family	\$8,400	\$16,800
Coinsurance (after deductible)	80% Plan / 20% Member	60% Plan / 40% Member
Primary Care Office Visit	\$30 copay; not subject to deductible	After deductible, see coinsurance
Specialist Office Visit	\$60 copay; not subject to deductible	After deductible, see coinsurance
Emergency Room	\$300 copay, then coinsurance applies (Copay waived if admitted)	\$300 copay, then INN coinsurance applies (Copay waived if admitted)
Inpatient Hospital — Acute Medical/Surgical	After deductible, see coinsurance No day limit Prior Authorization required	After deductible, see coinsurance No day limit Prior Authorization required
Inpatient Rehabilitation Services (IRF)	After deductible, 80% Plan Plan pays 60-day annual maximum per Plan Year Prior Authorization required	After deductible, 60% Plan Plan pays 60-day annual maximum (combined INN + OON)
Skilled Nursing Facility (SNF)	After deductible, see coinsurance 60-day annual maximum Prior Authorization required	After deductible, see coinsurance 60-day annual maximum
Mental Health / SUD — Inpatient	After deductible, see coinsurance No day limit Prior Authorization required	After deductible, see coinsurance No day limit
Mental Health / SUD — Outpatient	\$60 copay per visit; not subject to deductible No visit limit	After deductible, see coinsurance No visit limit
Home Health Care	After deductible, see coinsurance 100 visits per Plan Year Prior Authorization required	After deductible, see coinsurance 100 visits per Plan Year

Copays do not apply toward the deductible. All deductibles and out-of-pocket maximums reset on the first day of each Plan Year. Out-of-pocket maximum includes deductibles, copays, and coinsurance for Covered Benefits only. See Section 6 (Exclusions) for non-covered services.

SECTION 1 — INPATIENT HOSPITAL SERVICES

1.1 Acute Inpatient Medical and Surgical Services

Inpatient admission to a licensed acute care hospital for medical or surgical treatment is a Covered Benefit when Medically Necessary and Prior Authorized by MCA. Covered services include room and board, nursing care, operating room, anesthesia, diagnostic testing, and ancillary services provided during the inpatient stay. There is no annual day limit on acute inpatient medical or surgical admissions.

1.2 Skilled Nursing Facility (SNF) Services

Inpatient care in a licensed Skilled Nursing Facility (SNF) following an acute hospitalization is a Covered Benefit when Medically Necessary and Prior Authorized. Coverage is limited to sixty (60) days per Member per Plan Year. SNF care requires a qualifying inpatient hospital stay of at least three (3) days immediately preceding SNF admission.

SECTION 2 — INPATIENT REHABILITATION SERVICES

2.1 Coverage and Medical Necessity

Inpatient rehabilitation services provided in an acute Inpatient Rehabilitation Facility (IRF) or a designated rehabilitation unit of an acute care hospital are a Covered Benefit when ALL of the following conditions are met:

- The service is Medically Necessary as determined pursuant to MCA Medical Policy MP-019 (Inpatient Rehabilitation Services), in the version in effect on the date of service;
- Prior Authorization has been obtained from MCA before admission, or as required under the concurrent review program for continued stay; and
- The treating facility holds current CMS certification as an Inpatient Rehabilitation Facility or is a distinct-part rehabilitation unit of a CMS-certified acute care hospital.

2.2 Annual Benefit Maximum

Coverage for inpatient rehabilitation is limited to a maximum of **sixty (60) days per Member per Plan Year** across all facilities (In-Network and Out-of-Network days are combined toward this maximum). Days in excess of this maximum are not a Covered Benefit and are the Member's financial responsibility. Exhausted days do not apply toward any Out-of-Pocket Maximum.

The 60-day inpatient rehabilitation maximum is tracked across all admissions within a Plan Year. Prior Authorization requests submitted after the maximum has been reached will be denied as a benefit limitation, not a medical necessity determination. The Member's right to appeal a benefit-limit denial is the same as for any other adverse benefit determination.

2.3 Cost Sharing

Network Status	Cost Sharing
In-Network IRF	After In-Network deductible (\$520 individual / \$1,040 family), Plan pays 80% Plan; Member pays 20% Member
Out-of-Network IRF	After Out-of-Network deductible (\$1,560 individual / \$3,120 family), Plan pays 60% Plan; Member pays 40% Member. Balance billing by the OON provider may apply.

SECTION 3 — MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

3.1 Parity Statement

MCA provides mental health and substance use disorder (MH/SUD) benefits in parity with medical and surgical benefits as required by the Mental Health Parity and Addiction Equity Act (MHPAEA) and NRS 695G.170. Financial requirements (deductibles, copays, coinsurance) and treatment limitations (day limits, visit limits, prior authorization requirements) applicable to MH/SUD benefits are no more restrictive than the predominant requirements applied to substantially all medical and surgical benefits in the same classification.

3.2 Inpatient MH/SUD Services

Inpatient admission for mental health or substance use disorder treatment in a licensed behavioral health facility or a psychiatric unit of an acute care hospital is a Covered Benefit when Medically Necessary and Prior Authorized. Coverage is subject to the following:

- In-Network: After deductible, Plan pays 80% Plan; no annual day limit.
- Out-of-Network: After deductible, Plan pays 60% Plan; no annual day limit.
- Prior Authorization is required for all inpatient MH/SUD admissions and for continued stay reviews.
- Cost sharing is identical to inpatient acute medical/surgical services, consistent with MHPAEA parity requirements.

3.3 Outpatient MH/SUD Services

Outpatient visits for individual therapy, group therapy, psychiatric evaluation, and medication management are Covered Benefits with no annual visit limit. Cost sharing is identical to outpatient specialist visits, consistent with MHPAEA parity requirements.

- In-Network: \$60 copay per visit; not subject to deductible.
- Out-of-Network: After deductible, see coinsurance schedule.

3.4 Partial Hospitalization (PHP) and Intensive Outpatient (IOP)

PHP and IOP services are Covered Benefits when Medically Necessary. These services are classified as outpatient for cost-sharing purposes. Prior Authorization is required. Cost sharing is consistent with outpatient MH/SUD parity requirements.

3.5 Medication-Assisted Treatment (MAT)

Medication-assisted treatment for substance use disorders, including buprenorphine, naltrexone, and methadone maintenance, is a Covered Benefit. Office visit cost sharing applies to prescribing visits. Pharmacy coverage for MAT medications is provided under the Pharmacy Rider, if applicable.

SECTION 4 — OUT-OF-NETWORK BENEFITS

4.1 General OON Coverage

As a PPO product, Vista Access provides coverage for services rendered by Out-of-Network (OON) providers, subject to higher cost-sharing as shown in the Schedule of Benefits. OON providers have not contracted with MCA and may bill the Member for amounts exceeding MCA's allowed amount (balance billing). Members bear responsibility for balance billing amounts, which do not apply toward the Out-of-Pocket Maximum.

- OON Deductible: \$1,560 individual / \$3,120 family per Plan Year.
- OON Coinsurance (after deductible): 60% Plan / 40% Member.
- OON Out-of-Pocket Maximum: \$8,400 individual / \$16,800 family per Plan Year.

4.3 Emergency Services

Emergency services received at an OON facility are covered at In-Network cost-sharing rates. An emergency exists when a prudent layperson with average knowledge of health and medicine would reasonably believe that failure to obtain

immediate medical care could result in placing the Member's health in serious jeopardy. Balance billing protections apply to emergency services as required by applicable federal and state law.

SECTION 5 — PRIOR AUTHORIZATION REQUIREMENTS

The following services require Prior Authorization (PA) before services are rendered. Failure to obtain required PA may result in a reduction or denial of benefits. PA does not guarantee payment; services must also be Medically Necessary and otherwise Covered Benefits.

Service	PA Required	Request Type	Timeframe
Inpatient Hospital — Elective	Yes	Pre-service	At least 5 business days before admission
Inpatient Hospital — Urgent/Emergent	Yes	Concurrent	Within 1 business day of admission
Inpatient Rehabilitation (IRF)	Yes	Pre-service	At least 5 business days before admission
IRF Continued Stay Review	Yes	Concurrent	Per MCA concurrent review schedule
Skilled Nursing Facility	Yes	Pre-service	At least 3 business days before admission
Inpatient MH/SUD	Yes	Pre-service	At least 2 business days before admission
Inpatient MH/SUD — Continued Stay	Yes	Concurrent	Per MCA concurrent review schedule
Home Health Care	Yes	Pre-service	Before initiation of services
MRI / CT / PET Imaging	Yes	Pre-service	Before service date
Outpatient Surgery	Yes	Pre-service	At least 3 business days before procedure
Durable Medical Equipment (>\$500)	Yes	Pre-service	Before rental or purchase
Specialty Pharmacy — Injectables	Yes	Pre-service	Before dispensing

To request Prior Authorization, contact MCA Utilization Management at the number on the back of your member ID card, or submit electronically through the MCA Provider Portal. PA requests submitted after the service date will be evaluated as retrospective reviews and may be subject to late submission penalties.

SECTION 6 — EXCLUSIONS AND LIMITATIONS

The following services and circumstances are not Covered Benefits under this Certificate. This list is not exhaustive; the full exclusions list is incorporated by reference from the Group Policy.

- Custodial care or maintenance care where no measurable clinical improvement is expected, regardless of setting.
- Inpatient rehabilitation days in excess of sixty (60) per Plan Year (In-Network and Out-of-Network days combined).
- Services rendered without required Prior Authorization, except in emergency circumstances.
- Experimental, investigational, or unproven services as determined by MCA clinical policy.
- Services not Medically Necessary as defined in this Certificate and applicable MCA clinical policy.
- Services rendered by a provider who is not licensed or certified as required by Nevada law for the services rendered.
- Elective cosmetic procedures not required to correct a congenital anomaly, accidental injury, or medically necessary condition.
- Dental services, vision care, and prescription drugs, except as specifically covered under applicable riders.
- Services for which the Member has no legal obligation to pay, including services provided free of charge.
- Infertility treatments, surrogacy, or assisted reproductive technology beyond evaluation and diagnosis.
- Court-ordered services unless otherwise Medically Necessary and covered under this Certificate.

SECTION 7 — MEMBER RIGHTS: APPEALS AND GRIEVANCES

7.1 Right to Appeal

A Member or authorized representative has the right to appeal any Adverse Benefit Determination (ABD) issued by MCA. An ABD includes any denial, reduction, termination, or failure to provide or make payment for a benefit, in whole or in part, including a denial based on medical necessity, experimental or investigational status, or failure to obtain prior authorization.

7.2 Appeal Timeframes

Appeal Type	Member Filing Deadline	MCA Decision Deadline
Standard Appeal	180 calendar days from receipt of ABD notice	30 calendar days after MCA receives the appeal
Expedited Appeal (Urgent Care)	Concurrent with ongoing treatment or before discharge when a delay would seriously jeopardize health	72 hours after MCA receives the appeal
External Review	4 months after exhausting internal appeal rights	As required by Nevada law and NRS Chapter 695G

7.3 How to File an Appeal

Appeals may be submitted in writing by mail, fax, or electronic portal to MCA Appeals and Grievances. The Member or authorized representative should include the Member ID, date of service, provider name, and a written explanation of the basis for the appeal. Supporting clinical documentation may be submitted with the appeal or within the applicable timeframe.

7.4 Grievances

A grievance is a complaint about any aspect of MCA or a provider's service other than an ABD. Members may file a grievance at any time by contacting MCA Member Services. MCA will acknowledge receipt and respond within 30 calendar days. Members who are dissatisfied with the grievance resolution may request review by the Nevada Division of Insurance.

7.5 Nevada External Review

After exhausting MCA's internal appeal process, Members have the right to an independent external review as provided under NRS 695G.200 et seq. External review is conducted by an Independent Review Organization (IRO) certified by the Nevada Division of Insurance. The IRO decision is binding on MCA.

DEFINITIONS

Adverse Benefit Determination (ABD). A denial, reduction, termination, or failure to provide or make payment for a benefit, in whole or in part, including a denial based on medical necessity or failure to obtain prior authorization.

Covered Benefit. A health care service or supply that is covered under this Certificate, subject to all applicable terms, conditions, limitations, and exclusions.

Date of Service. The date on which a covered service is rendered, or the first date of a period of inpatient care. For concurrent review purposes, each day of an inpatient stay is a separate date of service.

In-Network Provider. A physician, hospital, facility, or other health care provider who has entered into a participation agreement with MCA to provide services to Vista Access PPO Members at negotiated rates.

Inpatient Rehabilitation Facility (IRF). A free-standing rehabilitation hospital or distinct-part rehabilitation unit of an acute care hospital that meets CMS certification standards for intensive inpatient rehabilitation services.

Medical Necessity / Medically Necessary. Health care services or supplies that are: (a) required to diagnose or treat an illness, injury, or condition; (b) consistent with the diagnosis and treatment of the condition; (c) in

accordance with generally accepted standards of medical practice; and (d) not primarily for the convenience of the Member or provider. Determinations are made pursuant to applicable MCA clinical policy in effect on the date of service.

Member. An eligible employee or dependent enrolled in the Vista Access PPO under the Group Agreement between MCA and the Group Administrator.

Out-of-Network Provider (OON). A physician, hospital, facility, or other health care provider who has not entered into a participation agreement with MCA. OON providers may bill the Member for amounts exceeding MCA's allowed amount.

Plan Year. The twelve-month benefit period beginning January 1 of each year and ending on the last day of the period. For this Group: Calendar Year (January 1 – December 31).

Prior Authorization (PA). The process by which MCA approves coverage for certain services before they are rendered. PA is required for the services listed in Section 5. Approval of PA confirms benefit coverage eligibility but does not guarantee payment if other conditions are not met.

Total Billed Charges. The charges submitted by a provider to MCA for services rendered, before application of network discounts, deductibles, or other cost-sharing. Used in certain benefit calculations and appeal authority determinations.

This Certificate of Coverage is confidential and intended solely for the enrolled Member and plan administrator. Unauthorized distribution is prohibited. | Mojave Crest Assurance Company | Nevada License No. MCA-NV-2019-0034